STATE OF MARYLAND

Advisory Council on Prescription Drug Monitoring

Kaiser Permanente Columbia Gateway Medical Center

7070 Samuel Morse Drive

Columbia, Maryland 21046

December 4, 2009

9:30 a.m.

Before the Honorable John F. Fader, II, Chairman

Reported by: Kathleen Vetters, CR

ALSO IN ATTENDANCE:

LINDA M. BETHMAN	DR. J. RAMSAY FARAH
DONALD TAYLOR	DR. DEVANG H. GANDHI
BRUCE KOZLOWSKI	JOHN J. MOONEY
DR. MARCIA D. WOLF	HENRY S. CLARK III
DR. NICOLETTE MARTIN-DAVIS	DELORA R. SANCHEZ
JANET GETZEY HART	ANN T. CIEKOT
MARY E. JOHNSON-ROCHEE	ELLEN L. KUHN
LARAI FORREST EVERETT	MANDY DAVID
GWENN HERMAN	GAIL AMALIA B. KATZ
MICHAEL J. WAJDA	GEORGETTE P. ZOLTANI
DR. PETER COHEN	DAVID SHARP
ALAN FRIEDMAN	LINDA L. STAHR
SHIRLEY DEVARIS	

(Whereupon, the meeting of the Advisory Council commenced at 9:36 a.m.)

JUDGE FADER: Well, let us get started with all of this. To begin with, are there any corrections, additions, comments with regard to the minutes of the last meeting, which no doubt everybody read over three times last night?

(No response.)

Hearing none, can I have a motion to approve the minutes of the last meeting? Bruce, second. All in favor? Aye. No Nay, okay.

Okay. Here is the order that we're going to take these today. Circle No. 5, because that's the one that is really going to consume a lot of our time. The Database.

I want to start with No. 13, which is Public Policy. I'm going to do 12, 13, 14, 15 and then go back to 1.

I'm not quite sure what the person who recommended this wanted. We're talking about public policy. Here is the way I see it. There's plenty of

public policy in all the Whereas clauses that were part and parcel of the 2006 legislation.

There is plenty of public policy in the 2005 report of Joe Curran, and there's plenty of public policy on the DEA website to indicate that drug diversion and drug abuse is a big, big problem.

So I thought that outside of making references to those sources, that we would just, in an introductory paragraph, make a statement to that effect. And if anyone in the legislature really doubted that, then they could go back. But outside of that, I am not so sure what else anyone wants here, and I would like to throw that open for discussion.

DR. WOLF: I think you were the one that put it in there.

JUDGE FADER: I don't think so, but I don't remember. I have trouble remembering what happened yesterday. That is Recommendation No. 13, Public Policy.

Again, all I do is propose to make this in

the preamble, which would be not more than three-fourths of a page, and a footnote referring to the all of these sources.

Does anyone want anything else? Anyone object to that or have anything else? Is there any discussion? Just to say it's a big problem and here's --

DR. FARAH: Yeah. I think a number of issues why it is critical that we do have some kind of an emphasis.

We are proposing a project, a program, with a fiscal note based on information, which is a few years back, and which we truly believe is a problem well worth having invested our time and effort and capital to get where we are.

I think if we do not present, just upfront, a very solid, reasonable argument -- why we're doing what we're doing -- I think it's sort of like counterintuitive of expecting to move on substantially without a very compelling situation.

So I feel that it is critical to report

that and just make sure we have the proper emphasis.

JUDGE FADER: We can encapsulate the conclusions that were made by the legislature in the Whereas clause. So we can do that. What else should we do? Mary.

MS. KATZ: Are we implying in this -- excuse me -- that the PDM is going to help solve the problem?

JUDGE FADER: No. We're just saying there's a problem and it's up to the legislature to decide whether or not --

Mary, I looked at your website. Some of your information goes all the way back to 2005. Some of it is latest through August of 2009, as far as statistics. What do you want to put here as far as the latest statistics with regard to prescription drug usage?

MS. JOHNSON-ROCHEE: I think for DEA, the information that we cite most frequently, when we're dealing with our -- industry. We'll go to the statistics that are compiled by SAMHSA with the drug use survey, the national drug health survey, that is

done annually.

That is probably the most comprehensive set of statistics that covers the widest population, where people make admissions to what their drug use has been over the last year, or whatever period they are being asked questions about.

JUDGE FADER: Can you send me Monday, in some type of format, PDF, Word, or whatever it is, a copy of that report?

MS. JOHNSON-ROCHEE: Absolutely.

JUDGE FADER: Okay. So I'm going to create an exhibit and I'm going to put that in there, and I'll put the Whereas clauses in there, and we'll capsulate. And I will pass it by Ramsay and Mary and see what they say about it. Does anybody want to do anything else?

(No response.)

JUDGE FADER: Okay. Anything else with regard to this?

(No response.)

JUDGE FADER: Hearing none, let us go to 12, the Technical Review Committee. I can't remember --

it's mostly because I can't read my own handwriting -- who suggested this. So perhaps someone can speak up here.

DR. WOLF: We did, as part of the access to the database.

JUDGE FADER: Okay. And we are?

DR. WOLF: We are the subcommittee group that -- we are Ramsay, Devang, myself, Gail, Linda and a couple others.

JUDGE FADER: Okay. Can you tell us what you had in mind?

DR. WOLF: I can.

JUDGE FADER: Let me just say this as an introductory. I have seen some references over the years in the New York Times to different local groups of computer and technical people getting together from different fields.

Surprisingly, to me, because I don't know much about those fields, somebody that's working for Walmart, somebody that's working for Super Fresh, somebody that's working for this business or that

business all meet and discuss the problems and applications of their respective businesses. And a lot of them have had some success in helping other people with applications that people normally wouldn't think of.

So that is the only thing I really know about this. And, Marcia, why don't you tell us what you want to tell us about this.

DR. WOLF: It was supposed to be a professional technical review committee, and they were going to be physicians primarily. And I think we decided last time -- I'll look for my notes from last time -- that we were also going to have an attorney who did not have a vote on the committee, and that there was going to be one other physician.

Basically, it was going to be physicians and one nurse that are certified. A certified addiction medicine specialist, a PM&R, a pain specialist, a pharmacist, an oncology nurse or pain nurse, a pain-treating psychiatrist, legal counsel, and an anesthesiologist.

The purpose of the committee was to provide clinical context towards the data. Also to be able to come up with education or advice in response to law enforcement or specialty board requests, receive the data that flags.

We agreed to a five by five. So five or more pharmacies, five or more prescribers involved. And then to review that data, and then forward it to the appropriate law enforcement or to the appropriate jurisdiction. And then also to review the redacted data for examples of grossly outlying physicians, or grossly outlying dispensers, and to provide some educational information to them as well.

So, basically, the Technical Committee would be the committee that receives the data from the data mining but we're calling it -- what are we calling it now? We're calling it data dredging, as opposed to data snooping.

JUDGE FADER: Would this be the material that would be assembled each year on their annual reports or what?

DR. FARAH: Yes. I think also, at some point in time, you're going to be looking for information or data that reflects the impact of the program. The size, magnitude of the issue. You're going to get requests for grants that are going to ask to get outcomes of all this effort, whether it makes sense or not.

MS. KATZ: But I -- annual, I saw as very immediate.

DR. WOLF: No, there's two different --

DR. FARAH: That's exactly. And when these people have a chance to look at the information coming out and give some kind of a judgment call so that the big advisory board at this meeting will have a little bit more information with clarification from the technical group about this. Because the advisory board is going to make a lot of decisions. This group has specific expertise in certain areas, and so it would be a good resource for the advisory group in making decisions as to where they can go from there.

DR. WOLF: We also thought that the Technical

Committee would be more of a day-to-day type of a reactive committee, as opposed to the entire advisory board.

DR. FARAH: Correct.

DR. WOLF: So that they would actually get the data that the system flags, or the requests that come in from law enforcement if they want any kind of information or interpretation to the data.

MS. KATZ: I saw this as a group that would meet very regularly, probably often, and in an emergency situation they could even meet by telephone.

DR. FARAH: Absolutely. But electronically for urgent issues to resolve. That's why it needs to be in a small group.

MS. KATZ: Remember when we had the state policeman from Virginia and he talked about the fact that the twelve assigned state cops had been specially educated about issues relative to drugs? This, to me, is a much further support system and it actually is where things will start, and maybe stop, so that certain data that is suggestive could be eliminated

from concern. And, really, because of the nature of the people on the committee, only the things that really seem legitimate will be investigated.

JUDGE FADER: If I got anything in writing from you, I'm afraid I lost that.

DR. WOLF: I e-mailed it to you too.

JUDGE FADER: Okay. Well, I'm going to have to pick that up from you because I messed that up. All right.

DR. WOLF: You may have it listed as under Recommendation No. 6.

JUDGE FADER: Okay. All right. Well, here is the situation. You're going to recommend, separately, by legislation, that this be created, to report to the advisory board? Is that what the situation is?

DR. WOLF: We've talked about the fact that there are letters that need to be generated, whether they are sent to pharmacies about their dispensing, or whether they are sent to physicians. I don't know if we're going to decide to send them to individuals.

This would be the committee that would generate those letters, unless we take the human element out of it and just have the system generate the letters when it flags a certain amount of data.

MR. KOZLOWSKI: Exactly right. Those systems are 30 years old at this point in time and they auto-generate. The software identifies aberrant practices. It makes no accusation. It sends it to the attending physician. It sends it to the dispensing pharmacist. They get to review it, use it if they want to, and not use it if they don't.

JUDGE FADER: All right. Let me ask you this. Can we talk about this and vote on this on three separate issues?

First of all, do we need or is it advisable that we have something like this? Secondly, do we ask that the legislature create it by legislation? Or thirdly, do we recommend that the advisory committee consider such a subcommittee?

So, number one is do we need, or is it advisable to have something like this? Number two,

should we ask the legislature to put it in the legislation. Or number three, should it just be a recommendation that the advisory board create such a subcommittee?

Those are the three elements of this that I see that we should discuss.

DR. MARTIN-DAVIS: If we leave it up to the legislature, then who would choose the individuals versus if you're saying you leave it up to the advisory board and then the advisory board --

JUDGE FADER: If we would recommend that it would be part of the legislation, then we would recommend that the legislature create this and appoint the following people to this and that this would be their duties.

Secondly, if we decide to recommend that the advisory council implement such a body, then we would say we felt that it should be these people and that should be the duties.

DR. WOLF: Along those lines, one of the things we talked about was providing these individuals

with some kind of an immunity. And the way to do that would be as if they were considered technically employees of DHMH and be paid either a stipend or a per diem or something like that so that they could do their activities with some kind of immunity.

JUDGE FADER: Whoever the legislature says has immunity, has immunity.

DR. WOLF: Right. So I'm saying I think it needs to go through the legislature, let the legislature do it as opposed to the advisory committee picking these people.

JUDGE FADER: Well, that's not necessarily so, because the legislature says that the advisory committee and all designees of the advisory committee have immunity there.

DR. WOLF: Okay.

JUDGE FADER: But, statutorily, the legislature is the only one that could really create immunities, except in certain circumstances the Court of Appeals does it. But that is very, very rare.

Remember now. Need is number one on the

voting. And, secondly, two or three, that we recommend that the legislature create this, or number two, that the advisory board implement this.

DR. FARAH: Just a quick point of clarification. Could it be such a way that the legislators' legislation would enact the creation of this subcommittee, to be a subcommittee of the advisory board with the specific designations of the disciplines as we have outlined here from the various areas?

JUDGE FADER: Sure. We have here Recommendation No. 2.

DR. FARAH: We have already recommendations which this Board will appoint somebody from whatever it is. They may decide addition medicine will appoint their people, pain people will appoint their people, et cetera. But it will be a legislation that that subcommittee should exist.

JUDGE FADER: Recommendation No. 2 lists the duties of the advisory board. You can put in there that one of the duties would be to appoint a subcommittee consisting of these people to do this.

Sure.

DR. FARAH: From such sources.

JUDGE FADER: Yes.

DR. FARAH: And all the rest of the ramifications of that.

DR. WOLF: In regard to point one, I think all the discussion that we had --

JUDGE FADER: Now, just a second now. Bruce has something to say.

MR. KOZLOWSKI: Well, it's clarification. You talked about this in the context of people who are going to do review and send out letters. I just want to offer to you that's a people resource you don't need.

The technology is there. So for purposes of voting, let's understand whether we are voting on a capacity in which I think we can get consensus there's a need on, or we're voting on --

JUDGE FADER: They're talking about formulating the letters, not sending them out. They're going to push a button to send it out.

MR. KOZLOWSKI: Well, even the formulation is done. I mean, it actually goes through and puts the whole thing together for you. You don't have to --

DR. WOLF: But there's no judgment in it. There's no discretion. There's no judgment. It just comes out.

MR. KOZLOWSKI: That's exactly right.

DR. WOLF: If it triggers, it goes out.

MR. KOZLOWSKI: Right. And then the other piece is the group that would be looking at the --

JUDGE FADER: The context of the letters would be generated by this, by the advisory board.

MR. KOZLOWSKI: Exactly right. But it's pretty much boilerplate. But what I understood your other thought was, is a group who is going to do a review of aberrant practices and consider appropriateness for referral to law enforcement.

I think we need to be very clear when we talk about this which of the pieces we are voting on.

JUDGE FADER: Okay. Well, let's do number one. Is there a need for a group of this sort?

Everybody. Anybody say no? Okay. All right.

Number two. What are we going to do? Recommend to the legislature that it be part of the legislation that this is established? Or two, put it under one of the duties of the advisory board to appoint this? Otherwise, the Secretary would make the appointments if it is in legislation.

DR. WOLF: I think the one thing that we all fear is that this is going into a political type of a process outcome, and I'm asking a question here.

If you'd leave it up to a subcommittee of the advisory board, the advisory board is made up of a variety of different disciplines, a variety of public and other people, not just clinicians and physicians.

If you created it a subset of that, somehow can it be subrogated or changed, as opposed to if it's mandated by the legislation that the committee consists of this and they have these duties, so it doesn't turn into a political or other type of free-for-all.

JUDGE FADER: Well, I mean, personally, I just feel that this is something that the Secretary should do, and that one of the duties of the advisory board should be to receive information and to determine what to recommend to the Secretary to act on this. But that's up to you.

MS. KATZ: I think the Secretary should be appointing the advisory board.

JUDGE FADER: Especially since the Secretary has done just a wonderful job of appointing this committee.

MS. KATZ: Well, that's true. But if the Secretary appoints the advisory committee, and then the advisory committee is challenged to create this technical review committee, that should consist of -- and we list -- maybe the language should be, should consist of at least. Which would give them -- No?

DR. FARAH: No. Absolutely not. I believe that this is a subcommittee of the advisory committee, and the advisory board does have the oversight or activity or charge of this subcommittee.

I think the important thing in here is that a specific number of people are referred to by their respective specialty areas, so we make sure we have the qualified people in that and not a political issue.

I mean, the last thing I want is that becomes an appointment from the Secretary, because of whatever lobbying efforts, rather than because of the right kind of person doing it because they know what they are doing in that specialty area.

JUDGE FADER: So what are you saying?

MS. KATZ: So if we say that the Secretary creates the advisory committee and the advisory committee appoints people in the following slots: pain management specialists, nurse --

DR. FARAH: -- referred by the specialty societies.

MS. KATZ: Right. Then that should be -- I mean, it should be a very non-political process because, effectively, what's going to happen is the advisory committee is going to receive the names from

the appropriate specialty groups, and I can't imagine that they would do anything other than say, thank you.

JUDGE FADER: Bruce.

MR. KOZLOWSKI: I think the Judge is correct in the context of, you may want, you may desire, you may have concerns. You can't usurp the authority of the Secretary. The legislature will not allow that to happen.

JUDGE FADER: No.

MR. KOZLOWSKI: And so you need to, as the judge suggested, write language in the context of the need for a subcommittee, and let the administrative process move as the administrative process --

JUDGE FADER: Yeah, but who is going to appoint that subcommittee? Is it going to be the Secretary or the advisory board?

MR. KOZLOWSKI: The Secretary would take advice, as the Secretary would from his advisory committee. But the end result is --

JUDGE FADER: But is the Secretary going to make the appointment of these people?

MR. KOZLOWSKI: That's affirmative.

JUDGE FADER: Okay. Ramsay.

DR. FARAH: I think the advisory board should do it.

JUDGE FADER: The advisory board should.

MR. GANDHI: Well, a subcommittee of a board would normally be appointed by the board itself.

JUDGE FADER: Well, that's correct. But the advisory board is only an advisory board. So should they really be making any appointments whatsoever? That's the big question.

DR. FARAH: Okay. That's a good point.

MR. KOZLOWSKI: And technically they can't. An advisory board can't.

MS. KATZ: What kind of a board can?

DR. WOLF: The Secretary can.

MS. KATZ: Yeah, but if we change it from advisory board to some other adjective, what could --

JUDGE FADER: Well, you don't want to fool around with that because the legislature is not going to fool around with that.

MR. GANDHI: But these people will be drawn from the board, and the representatives of the board will be recommended by the specialty societies.

JUDGE FADER: Well, they may not be drawn from the board.

DR. WOLF: No, they may not be drawn from the advisory board. It will be different people.

DR. FARAH: Instead of an advisory board it will be a commission.

MR. GANDHI: Then how can it be a subcommittee?

DR. FARAH: -- a monitoring commission then.

JUDGE FADER: You don't. What you say is, there shall be this committee, and that the advisory board shall take recommendations from this committee and report it to the Secretary with comments. That's what you do.

MS. KATZ: Could you also say that the advisory board will solicit the membership of this review committee and then bring that to the Secretary for --

JUDGE FADER: Well, that goes without saying. I mean, if they are an advisory board, they are going to be able to do whatever they want to do. All right? To bring it, we say that there is a need for this.

I would say suggestion number one is that the Secretary make the appointments to this group, this assemblage. And two, that the advisory board solicit one of their duties, information, and reports from this board to pass along with their comments to the Secretary.

Now, secondly, what is the other alternative? That the advisory board appoint them.

DR. FARAH: The third part of that second would be the designation. I think the designation is critical here.

JUDGE FADER: I don't think anybody disagrees with what Marcia said as to who the individuals will be.

DR. FARAH: No, I mean if you're putting in the language, I think we need to put that proposal as part of the language.

MR. GANDHI: We supply that it's a committee of professionals --

DR. FARAH: -- from these disciplines.

MR. GANDHI: Yeah.

DR. FARAH: Recommended by whatever.

JUDGE FADER: All right. Let me go through it again. There shall be implemented a board -- what do you want to call it, Marcia?

DR. WOLF: The professional technical review committee.

JUDGE FADER: -- a professional technical review committee, members of which shall be appointed by the Secretary and include the following -- blah.

Secondly, that among the duties of the advisory board will be that the advisory board take the recommendations of this committee, make such comments as deemed appropriate, and pass that on to the Secretary.

DR. FARAH: In regard to appointments?

JUDGE FADER: We're saying the Secretary makes the appointments.

DR. FARAH: I mean, the pointer making a reference to that point.

JUDGE FADER: No, reference to what the recommendations are going to be. The Secretary would make the appointments, period, which is the only thing the legislature is really only going to go for in my opinion.

DR. FARAH: We're talking about the representation on that. That's what we're referring to.

JUDGE FADER: Well, Marcia is going to say who the representation should be. There's no problem on that. All right. Anybody have anything else?

DR. MARTIN-DAVIS: Just so I'm understanding the wording, the legislature is going to choose the members of the technical committee?

DR. WOLF: No, no.

JUDGE FADER: No. They are going to put in legislation as to there is a technical committee. It shall consist of the following individuals.

DR. FARAH: Disciplines.

JUDGE FADER: Disciplines. All right. Anybody have any questions with that? Everybody in favor of that? Okay.

And what that does is, of course, that preserves to the Secretary the right to make these decisions and these appointments. And as Bruce says, that's the individual who is the member of the executive branch of government who is charged with all of these responsibilities in the executive branch. The legislature says, make a report to us so we can see what's going on. But I don't think the legislature has ever or is going to interfere with that. All right. Any questions? Any comments?

(No response.)

JUDGE FADER: All right. Marcia, I'm sorry that got past me but it did.

Education, No. 14. Now, I've kind of listed for all of you here everything that I took off of these websites as to what everybody seems to be doing as far as education is concerned.

So anybody has any additions, suggestions,

comments, whatever, with regard to that, let me know. They have brochures. They put the statutes online. They have procedural manuals. They have all the things as far as HIPAA and confidentiality. There's yearly reports to the Governor, how to contact us.

That is all I thought you were all thinking of when you said education. You can go to a website and you can pull almost anything down from the website. There's brochures to put in physicians' offices, pharmacies and everything.

So let me shut up and see who else likes to comment on that.

MS. HERMAN: What about an area of presentation? Maybe having somebody going out and doing a presentation.

DR. WOLF: Like the Vermont, yeah.

JUDGE FADER: This is what this lady, Zilberberg, who thinks that Ramsay is the greatest thing since sliced bread. She wasn't really interested in talking to me unless I promised her I would say hello to Ramsay.

She says they do. They regularly go out. And here's what she says. Vermont is a smaller state. I can't remember how much smaller they are than us.

MR. SHARP: Vermont has about 600,000. A little less than Baltimore City.

JUDGE FADER: Okay. She says that individuals accompany her on the visits. The physicians, the specialists, they do grand rounds in the hospitals. They go to meetings to discuss this and that is the reason why I've put it as part of the recommendation. I mean, it's going to depend upon who has money and who the staff is.

DR. WOLF: It's more than that, too. Sometimes the target audience is the hardest audience to get because it's the people that don't go to grand rounds, and it's the people that don't attend meetings, and it's the -- or sometimes the ones you're trying to target the most and that they are very difficult to get hold of.

JUDGE FADER: I know that, but you can lead a

horse to water but you can't make the horse drink.

DR. COHEN: In New York state, I believe, to get a medical license you have to take a course of pain management and that's by law.

JUDGE FADER: Peter, our disciplinary boards have resisted, time and time again, any suggestions that there should be any specialized requirements as far as CEs are concerned.

I think that you're correct that they should, but I don't think there's any chance that any of these disciplinary boards are going to be receptive to anybody telling them what to do.

DR. FARAH: On the other hand -- may I? On the other hand, we have an agency that can do that. And if we have the legislation, then the DEA could say, I'm not going to give you a license to prescribe controlled substances without you having shown me a course that you know how to handle pain.

JUDGE FADER: Now, that the legislature has consistently done. The legislature has specifically said with regard to licensing nurse practitioners,

people who are in a specialty field, that they cannot say that they are qualified to do this, or practice in those fields, unless they take certified courses. So, yes, that has happened.

MS. JOHNSON-ROCHEE: Can we go back to DEA for a minute? Currently we do not have that in place. There are some states, such as Virginia, if you hang on a shingle that you are a pain management specialist, then you must have certain training. And, of course, SAMHSA has certain requirements for, say, those data-waived positions. If you are going to apply for the data, you have the training to provide addiction treatment. Maybe I misunderstood you, but --

DR. FARAH: But from the meetings I've attended there was some proposal language that if you are going to prescribe controlled dangerous substances, and you are renewing your license every two or three years to get it, that you should show some evidence of credit if you are requested to do so.

MS. JOHNSON-ROCHEE: We talked about that at one time.

DR. FARAH: That shows that you have taken courses of provisions, like Buprenorphine. Right now, if you're going to get to prescribe Buprenorphine, you have to have taken the eight-hour course to be able to prescribe Buprenorphine. I don't see why we don't already have a precedent.

JUDGE FADER: Well, let me ask you this. Is that not a regulation of the board, or is that legislation? Who has mandated that if you want to prescribe that drug, you must take it?

DR. FARAH: The federal government.

DR. COHEN: It's the law.

MS. JOHNSON-ROCHEE: It's HHS.

DR. FARAH: I can assure you that the Board of Medicine would never put in our statute that you have to take any course to be able to have that license.

It's just not going to happen because there is such a spread of different people doing so many different things, it just does not make sense. We have 25,000 licensed physicians. Out of the 25,000,

literally only 15,000 actually take care of patients.

So you cannot pass a regulation requiring people to take a course that they are never going to be able to use or want to use. It's no different than if you are requesting a license to do a certain procedure, that you shouldn't be proficient in that. So if you're going to write pain medication, it makes sense to take a course in responsible opiate prescribing.

As you all know, we've already had a course that about 90 people attended. It was very successful and we can duplicate this. So many credit hours in your cycle. But that should be more from the CDS point of view, maybe. If you to have your CDS licensure that you should take a course every so often. But not as a requirement of your licensure.

JUDGE FADER: Okay. Aren't we biting off, with this committee, more than the legislature told us to chew with regard to this item?

MS. KATZ: Are we talking about the use of the PDM by --

DR. WOLF: No.

MS. KATZ: I'm confused about where we're going here.

DR. WOLF: I thought they implemented a system where there was one CME thing that they had to do before you could get a license in Maryland. It was called a sense of balance. As I understand it, new licensees have to at least view that video.

DR. FARAH: Oh, that's what you're talking about. Yeah, we do have a set of videos on professional boundaries, and this kind of thing that --

DR. WOLF: But it talks about prescribing a pain medication, too.

DR. FARAH: Yeah, but it's not like a CE -- it's not like a credit --

DR. WOLF: No. It's not a credit, but it's mandatory.

JUDGE FADER: The law has that too. Before people can be admitted to the Bar, they made us take a full day ethics course that is given.

But that is part of the application

process, and it is part of the authority of the Board of Physicians and the Board of Pharmacy to require this as part of the application process.

Again, something I suggest to you that is not within our charge from the legislature. Bruce.

MR. KOZLOWSKI: Can I speak on behalf of Dr. Lyles, which he said I could do?

His intent on education was dealing with both the prescriber and the dispenser. Because his feeling being if the prescriber and dispenser weren't educated by the PDMP program, it was never going to achieve a reasonable number of participants and users and, therefore, its creative purpose was never going to be realized to any extent.

So in thinking back on earlier conversations, I think that's where the discussion happened to be going, was in that kind of education. That is appropriate for this -- it would appear appropriate for this group to make that kind of a recommendation, and that education of prescribers and dispensers be an activity that would be done. And

then the rest of that sits within statute from what U.S. boards are authorized to do and we shouldn't be discussing that today.

JUDGE FADER: All right. But what kind of education?

DR. WOLF: Isn't that better termed advertising?

MR. KOZLOWSKI: Yeah. I think when they talk about that is at the medical societies, the pharmaceutical association takes on a more proactive role. But I've got a group related to disparities, and ours just says to be sensitive to the need of education, and to the extent possible create programs or promote programs to better inform -- and then you could say dispensers and prescribers.

JUDGE FADER: Most of these people have online manuals for the prescribers, manuals and instructions for the dispensers. Maryland is going to do that.

MR. KOZLOWSKI: Okay.

JUDGE FADER: But outside of that, I don't

think there's anything else we can do except leave it up to the boards, as far as application and as far as disciplinary.

If the Disciplinary Board, the Board of Physicians, finds that a particular physician is prescribing, not in accord with what's out there, they can say, we're not going to give you your license back, or we're going to suspend your license until you take this course and that course and things of that sort.

MR. KOZLOWSKI: It was different education. It's not about what's appropriate in prescribing and dispensing. It was awareness. An awareness campaign so that prescribers and dispensers actually went and used the PDMP system once it was created.

MS. KATZ: Okay. And that's what I heard in a lot of the different states that I talked to. That they had to let people know that the PDM was there and this is how you use it and this what it's for. Otherwise, you created this enormous system and then you had a 22 percent utilization rate which made the

whole thing kind of absurd.

JUDGE FADER: Now, here's number two up here. Initial contact by a letter to the dispensers and practitioners concerning the program, accompanied by forms for registration. And I guess we're going to put in there also as to how the system works.

DR. WOLF: Couldn't you have a tutorial online?

JUDGE FADER: They all do. From Oklahoma, which is 124 pages -- which is the most ridiculous thing I have ever seen in my life -- to a couple of the states that have 5,6,7 pages.

MS. KATZ: What I heard from a lot of the executive directors is that they saw their initial job, certainly within the first year, to go to as many meetings that already existed and get on to the agenda and spend 20 minutes telling whoever was there, this is here, this is how you use it, and this is what it's for.

JUDGE FADER: Right. Look at number five here. Pamphlets and frequently asked questions to

educate the public, dispensers, practitioners, and patients concerning the program. So don't we have everything included here? Does anyone want to add anything to that?

MR. CLARK: Yes, Judge. I think a simple sentence for law enforcement access. They are going to learn about this. They are going to want to know what they can do to access it, and I think that a simple --

JUDGE FADER: To add law enforcement personnel here.

MR. CLARK: A simple sentence would just say that access to this for law enforcement purposes is by subpoena.

JUDGE FADER: Okay. We can put that in five.

MR. CLARK: That's what I was thinking.

JUDGE FADER: All right. We can do that.

DR. WOLF: The question is, is there going to be some kind of technical support so when these people can't figure out all the idiot proof data.

JUDGE FADER: All right. Number seven. The availability of a help desk to assist individuals in

need of assistance regarding all parts of the program.

MS. KATZ: Most of them have about two FTEs, one being sort of an executive director and another one being a technical person.

JUDGE FADER: See, I went through about four or five of all of these websites and I pulled all of this information off of the websites. Does that satisfy you, Marcia?

DR. WOLF: Yes.

JUDGE FADER: Technical availability. Okay. All right. Again, except for the few comments here to add for law enforcement personnel, things of that sort, is there anything that we want to add to this? All in favor of this recommendation No. 14, say aye.

DR. WOLF: Aye.

JUDGE FADER: Any opposed?

(No response.)

JUDGE FADER: All right. Outcome, No. 15. The two statutes that I picked up were from Florida and Virginia, that I thought personally were the best, that just say as part and parcel of what the advisory

council is supposed to do, or the Secretary is supposed to do, is an evaluation of the program. So I just thought that would be part and parcel of the report that the Secretary is to make, and throw that open for discussion.

It's amazing. A lot of the programs don't have anything to do with evaluations. Bruce said some of them are 30 years old and take the position of a lot of people: the hell with you.

MR. KOZLOWSKI: There's Linda, I guess, who can speak to it better than I do. But like the partnership program, it just basically says to evaluate and report back in two years. They actually did a one-time two-year because you need time to get it up and operational before you do your evaluation. I think that's reasonably common, it is not on the programs?

MS. BETHMAN: Yes.

DR. WOLF: So we leave up to the advisory committee what it is that they're actually going to be evaluating?

JUDGE FADER: Well, really leave up to the

Secretary and the Secretary's annual report. And among the duties of the advisory committee, or the advisory board, is to evaluate. But, once again, it is the Secretary who is the one responsible for this in every cabinet position.

DR. FARAH: I have a question. We already proposed -- because here on the Florida model you just put in here, it said the Department shall establish policies and procedures as appropriate regarding the reporting. I thought that we already decided that we're going to put that in legislation.

JUDGE FADER: All I am concentrating on here is what's underlying as far as evaluation.

DR. FARAH: Okay. So the question is, is the Secretary of the Department of Health and Mental Hygiene, who is who you are referring to here, responsible to report on the evaluation, or is it the advisory board?

JUDGE FADER: The advisory board advises the Secretary. It's the Secretary that is the one that's responsible to the legislature.

DR. FARAH: All right. I feel, of course, the obligation of putting this information rests on the advisory board to do the evaluation and present it to the Secretary.

JUDGE FADER: When you get to No. 2, which is the recommendation of the advisory board, one of the responsibilities of the advisory board on page 3 is the design and implementation and ongoing evaluation component of the program.

DR. FARAH: Exactly.

JUDGE FADER: Okay. So that will take care of that.

MS. KATZ: Somewhere it is important to set some goals and objectives because I know that in writing the implementation grant, there has to be very clear goals and objectives set. So I thought that was language that could be attached. The evaluation criteria would be those goals and objectives.

JUDGE FADER: Can I just say then, with regard to this recommendation and the outcome, that it be part and parcel of the duties of the advisory board.

But we want to emphasize this by making a special recommendation as to the importance of this, but that it was really covered by the advisory board. Anybody have any comments on that?

DR. WOLF: I actually have a question about this whole thing because there's two issues with effectiveness and outcome.

One is the actual workings of the committee and the data and how effective it is and how many people are using it.

The other is really more, what kind of an impact does it have on the state of affairs of the status quo, and is there going to be some mechanism to evaluate that? You know, is the incidence of abuse going down? Is the incidence of kids winding up dead in the emergency room?

JUDGE FADER: That's the evaluation program. Gail is going to tell you that one of the big things that occurred in San Diego was that all of these PDM systems say they have no idea whatsoever whether or not these programs, or any of them, are effective.

MS. KATZ: But one of the things that has to go into this implementation grant is a picture of Maryland in terms of deaths by overdose, ER admissions for overdose, arrests for overdose, those being the significant criteria. And so I would assume that the goal and objective is from a public health standpoint, to look at those and say, does a PDM have the effect of producing that?

JUDGE FADER: Mary, is that not all included in that annual report?

MS. JOHNSON-ROCHEE: The report I'm telling you about is a national report. I don't know that it --

MR. GANDHI: It's the National Survey on Drug Use and Health.

MS. JOHNSON-ROCHEE: Yes. I think there is some state data in there.

JUDGE FADER: Well, can you get me -- who can talk to us about Maryland? Does Maryland have any special statistics on any of this?

MS. JOHNSON-ROCHEE: Some of the things that

we would look at for Maryland, I know we've gone to the Medical Examiner's Office. I would imagine that the Department of Health here maintain some statistics about what's happening in terms of drug abuse --

JUDGE FADER: Okay. We can take a look into that to plug it in, but one of the things Joe Curran said in the report that was in 2005 was the statistics, as far as the overgrowth, and I have a copy of that here.

MR. GANDHI: There are several national surveys that have been annually or bi-annually, so monitoring the future as far as adolescents and that's every year, I believe.

DAWN is another one, Drug Abuse Warning Network. It collects data from emergency rooms for drug cases. So all of these have the capacity to give some state-related numbers.

JUDGE FADER: Okay.

DR. MARTIN-DAVIS: Have we even talked about diversion, or just overdose and death and things like that?

JUDGE FADER: We are talking about diversion, because the whole idea of this is to cut down on the --

MS. KATZ: Yes, one of the statistics is arrests.

DR. MARTIN-DAVIS: Okay.

JUDGE FADER: To keep these drugs out of the hands of people who the physicians don't certify have a medical need for these drugs.

DR. FARAH: But one of the things that we can do are to set up these unsolicited reports that talk about trends and numbers that we can predict. So while there might be triggers that would make an action, there's no reason why we cannot have this blind data give us trending, year after year, as to how many of these fall out.

JUDGE FADER: There are a number of these websites that have statistical data from the states on the website as to the problems with these drugs.

Now, once again, I'm in this recommendation for evaluation and what I'm saying to you is, is it not our purpose to state that we recommend this as a

special recommendation but really feel that that would be included in the responsibilities of the advisory board?

Does anyone have any additions, recommendations, anything of that sort? In other words, we're making the special recommendation to the legislature to make sure that they don't forget about this. Not that they're going to. Anybody have any questions, comments, anything on that? Yes.

MS. BETHMAN: I'm not sure, but I think this program probably would be subject to sunset review as well.

JUDGE FADER: To what review?

MS. BETHMAN: To the sunset reviewers. So it would be reviewed anyway, regardless of what's put in the legislation.

JUDGE FADER: Can you tell everybody here who may want to ask what is sunset. It's one of the few things I do know.

MS. BETHMAN: I don't know exactly -- the sunset review process -- you could probably speak to

that more. It's based on what type of program it is, whether it's subject to the sunset review, and I guess it's how this program is created that really triggers the analysis. And if it is covered by the sunset review process, is it every ten years?

MS. STAHR: Uh-huh.

MS. BETHMAN: Every ten years the legislative auditors come in and take a look to see if it's running effectively, efficiently, and sometimes, in rare cases, it has been determined that they will sunset the program, which means shut it down. I don't know if you have any more information.

MS. STAHR: Linda Stahr, Department of Legislative Services. It's my department that does these sunset reviews.

MS. BETHMAN: Great.

MS. STAHR: Typically it's the regulatory boards that are subject to sunset. So if the program was to be housed in the Office of Drug Control, I don't know that it necessarily would be subject to sunset.

MS. BETHMAN: In D.D.C?

MS. STAHR: Right. Because I don't think that that office is subject to sunset. It would have to be in the legislation.

JUDGE FADER: What you're doing, and you ought to stop it, excuse me -- is there are so many statues out there that you see now subject to abrogation. Okay.

Now, this is just a mindset of the legislature is we're putting this thing out here. We want to see how it works. We want to see what is going in here, but we're telling you that we are going to pull the plug on this. Okay? So they're doing an awful lot of that with health care now, aren't you?

MS. BETHMAN: Yeah, they are.

JUDGE FADER: Okay. I don't like that because it takes up too much space in the books.

MS. BETHMAN: Okay. So you don't consider drug control to be a regulatory body even though they issue CDS permits?

MS. STAHR: I don't think drug control is

subject to sunset.

MR. KOZLOWSKI: That is the normal sunset protocol but it doesn't preclude the legislature. Which they've done is to say sunset in five years, and then you have to come back and justify the legislation to continue on.

MS. STAHR: No, that's a separate thing really. There are provisions and statutes that are subject to abrogation. It typically would be three years, five years. The sunset law is more specific and requires a specific evaluation which has to be presented to the legislative committees.

MR. KOZLOWSKI: That's very defined.

MS. STAHR: Yes, there's a defined process in the statute for doing those reviews.

JUDGE FADER: It would not be wise to make drug control subject to sunset provisions because 95 percent of it is a mirror of federal law. So if they did make it sunset, the federal law isn't going to go away anyhow.

MR. KOZLOWSKI: And they have to comply. So

all you really need is the fact that you're going to report and that's it.

JUDGE FADER: All right. We all in agreement here?

DR. COHEN: Say what you have to say, please.

JUDGE FADER: The situation is that the recommendation is that we are making a specific recommendation as to this point. The evaluation into the future, because we feel that it is so important, but actually the emphasis of this, and the provision of this, would be with regard to the advisory board's requirement and duties to report on this to the Secretary.

DR. COHEN: Okay. Do you need to specify that certain outcomes or measures will be developed? That we're actually targeting certain --

JUDGE FADER: I think that's up to the advisory board and up to the Secretary because I personally don't think that we can see into the future.

DR. COHEN: But, I mean, that you wouldn't want that codified.

JUDGE FADER: My personal belief is that there is so many things that we're changing that it would be a mistake to codify something and then try to get rid of it later when the new kid on the block comes in with something better. I think if this is something you need you'd have to leave up to the advisory board.

DR. COHEN: That's what I mean. That the advisory board would have developed those. But you would have to put that in writing, that would be expected, the advisory board would develop. What is the meaningful outcome?

JUDGE FADER: Yeah. I'm not so sure that you have to put that in there when you say that they are to evaluate. In fact, I would think legally you don't.

DR. COHEN: Okay.

MR. TAYLOR: These programs are very hard to prove outcome anyway. You may see a trend, but to actually show and prove an outcome is pretty hard with these programs.

JUDGE FADER: All right. Anybody have any

questions, any comments? Are we all in agreement with regard to No. 15?

DR. WOLF: Yep.

MR. TAYLOR: Yep.

JUDGE FADER: Okay. No. 1, Drugs included. Now, I'm waiting for No. 5 until the liquor store delivers. All right.

Well, here is the situation. With great deference to Peter, Ramsay, Marcia and everybody else, I am not convinced that we have enough information on board to recommend specifics of other drugs of interest that would be added to the legislation.

I am convinced that this is the reason that the legislature struck it in the first place. And then I'll ask if anybody has any comment.

Now, I did hear -- because Bob Lyles was very emphatic to Governor Ehrlich's veto, so I decided to put his veto letter here, as Bob asked me to put it someplace, to show the concerns.

I think that the legislature is going to be

interested in how we address, and should address, any concerns that Governor Ehrlich expressed in this. All right. Comments? Questions?

DR. COHEN: So what I think you're saying is that on page 1, it's that paragraph after commentary, all prescription medication is going too far?

JUDGE FADER: I'm also saying that I don't think we have enough to say that, anything except Schedules II through V. I don't think that the legislature is going to be convinced by any argument that we make about any drugs of impact.

DR. COHEN: You haven't offended my sensibilities.

JUDGE FADER: Well, I'm just saying that they struck it out first, Pete, okay? They did that for a reason because they weren't convinced then, and they're going to sit there and they are going to ask a question. All right, Dr. Cohen, tell me one drug additional and why you would say to the Secretary it should be -- well, they are going say two because everybody can say one.

The question is, can you come up with this and we've struggled with this and nobody has been able to come up with it, in my humble opinion. So I suggest we think about dropping it.

DR. FARAH: I'm sorry, Judge, let me understand your question. Is your question, tell me one drug why you should track --

JUDGE FADER: In my opinion, we should consider including in Schedules II through V, and drop whatever drugs are added by the Secretary, because I don't feel -- because we have sufficient proof to answer a question in the legislature.

Chairman Hammond isn't going to ask me to tell him what drug, because he knows I don't know. So he is going to say, have you brought Dr. Cohen here with you? Yes, I have. Have you brought Dr. Farah? Yes. Have you brought --

Okay. What do they say? Give me two examples of drugs you would recommend to the Secretary to be added to this list and why. And I don't think we've proven that.

DR. WOLF: Azithromycin.

MR. FRIEDMAN: Why?

DR. WOLF: Because when mixed with methadone it dramatically can increase the methadone levels and can cause death.

MR. GANDHI: I think we are going into drug interactions, which is a clinical issue.

DR. WOLF: Right. It's a clinical issue.

MR. FRIEDMAN: Yes. So are you looking for drugs of abuse and doctor shopping, or are you looking for potential drug interactions, which is a prescribing and dispensing consideration?

DR. COHEN: I agree that I've got a apothecary system here and I can do all that. What we're worried about is this distribution and lack of consciousness around prescribing. So I stay we stick to the one --

MR. GANDHI: Yeah, II through V seems reasonable.

MR. FRIEDMAN: Don, in Maryland Schedule V, can you sign over the counter for that or do you have

to get it on prescription?

MR. TAYLOR: Prescription only now.

JUDGE FADER: Yeah, so the biggest example of that is Robitussin AC. You can't get that, except with a prescription, in the State of Maryland, but you can go over to Delaware and you can buy it in four ounce bottles from every pharmacy you hit up the line. Happy Harry's will be wonderful.

MS. JOHNSON-ROCHEE: Just to add to it, I think if you go throughout every state, you're going to find there's a drug popular in almost every jurisdiction that gives some other indication or -- I just don't think we can isolate out --

DR. FARAH: No. I think part of the problem is that I think is where this originated is the use of Dextromethorphan by children who are constantly using that as the drug of choice. Pseudoephedrine was one of them.

These are drugs that have been taken off and put behind the counter because of that, and they are not being tracked. They are definitely a public

health issue.

JUDGE FADER: But they are not on prescription.

DR. FARAH: But they are not on prescription. Precisely.

JUDGE FADER: So how are we going to track them?

MR. GANDHI: It's only in hindsight that we know that these were problems.

DR. FARAH: Exactly. The only issue is, when you start tracking other medications, I'm concerned about the whole problem with mental health medications and are we starting now to get some opposition of people because of fear that goes out beyond of just focusing on drugs of abuse?

So are we going to get some resistance and say, oh my God, you've got to know that I' m on Risperidone, you've got to know I'm on Depakote or whatever it is.

JUDGE FADER: My wife says it's easier to say who is not on something.

DR. FARAH: Yeah. So I think sticking II to V at this point -- plus, one more thing, it's going to be easier when we look at finances and vetting for information and processing. If the future brings different, then we may have a compelling reason to go --

JUDGE FADER: Then we can go the back to the legislature. But, once again, I'm going to sit there and Chairman Hammond is going to ask me and I'm going to say, I don't know. Here's Dr. Cohen, here's Dr. Farah, here's Dr. Wolf, et cetera, and if they don't have any answers, I can tell you what the situation is going to be.

MS. KATZ: I think we just have to focus on the issue that we came here for. And, yes, we could build it out and do other clinical things, but we just can't.

JUDGE FADER: How about then having the recommendation of II through V indicating that we take note that drugs of impact was in the 2006, that we feel that problems with that may arise in the future with

the development of other drugs and trends, and perhaps at a future time we may come back to the legislature and ask for further consideration. Marcia.

DR. WOLF: One of the things I was just asking about was whether the male androgens, the steroids that the athletes would use, whether they are all Scheduled or not all Scheduled.

MR. TAYLOR: There are a few exceptions. If they are in combination in a smaller percentage, there are some exempt androgens.

Maryland considers them prescription but federal doesn't in some instances. Same thing with Soma, which the DEA is now considering making Schedule III.

MS. JOHNSON-ROCHEE: Anabolic steroids are Scheduled.

MS. BETHMAN: What are Scheduled?

MS. JOHNSON-ROCHEE: The Schedule III involve steroids.

JUDGE FADER: Anabolic are Scheduled steroids now?

MS. JOHNSON-ROCHEE: Anabolic steroids are Schedule III. They've been since 1990.

JUDGE FADER: All right. Mary, what else do you want to say about that?

MS. JOHNSON-ROCHEE: I think to be consistent, especially if we are going to look in the future to extending this to other states where we're sharing information, the practical thing to do is to stick with Schedule II through V.

JUDGE FADER: All right. Everybody in agreement? Anybody have any questions? Anybody have any comments?

(No response.)

JUDGE FADER: Would you then please turn over, just on Governor Ehrlich's veto message, and just keep that part to discuss the things that he addressed in that, but the rest of the recommendation is adopted. Advisory Board.

MR. FRIEDMAN: You're going to change it to V, right?

JUDGE FADER: We're going to change to V.

DR. WOLF: And II.

JUDGE FADER: II through V. Surprise, surprise. States that have said that you can now have medical marijuana are running into problems. Surprise. Mary, you didn't know that was going to happen, did you?

MS. JOHNSON-ROCHEE: No, I didn't.

JUDGE FADER: Yes, of course. All right. It's so easy. Let's put marijuana on Schedule II, regulate it through prescriptions, and see what happens. But, anyhow, nobody is asking me. Recommendation No. 2. The Advisory Board.

DR. FARAH: Did we address everything here yet?

JUDGE FADER: In No. 1 we did.

MS. KATZ: No, we're going to keep going back to it.

JUDGE FADER: In No. 2, number 1, we did talk about who shall be on the advisory board. We did indicate some changes. I think all of these changes are incorporated here. We did not discuss that much

the duties of the advisory board, but we did in some detail.

So, number one, can we talk about, first of all, the composition of the advisory board, see whether or not anybody has any comments on that?

DR. FARAH: Wait a minute. I mean, we've gone through this and I still don't see it here.

JUDGE FADER: Well, the composition is on page one.

MS. KATZ: I know that you all are going to be totally surprised that I am going to say this but, when I look at this, it is not particularly balanced from the standpoint of the patient.

I mean, there are going to be two citizens who represent the perspective of pain patients and there will be a lot of physicians who treat those patients, but there's an enormous amount of law enforcement, as well. So I am concern about the balance issue. Maybe I can be comforted by some of your comments.

JUDGE FADER: Well, Dr. Lyles told me on the

telephone that he's been advising patients about pain medication for so many years, and really never truly understood what it was all about until he was forced, with his gallbladder operation, to be on pain medication.

DR. WOLF: There were a couple of just clinical typos that got left out. In number 7, at the end of the first line at number 7, it's expertise in areas of clinical practice.

JUDGE FADER: Just a second, where is that?

DR. WOLF: Under the composition of the advisory board, number 7.

JUDGE FADER: Areas of clinical practice.

DR. WOLF: Correct. Clinical needed to get inserted in there. And, again, as a technical kind of thing, in subset I under that number 7, it's the Maryland Society of Physical Medicine and Rehabilitation. It's just the words are flipped around. It's the MSPMR.

JUDGE FADER: Maryland Society of Physical Medicine. We'll change this. All right. Anything

else, any other comments?

MS. KATZ: It says addition medicine. It must be addiction.

JUDGE FADER: Addiction. That's the reason spellcheck didn't pick it up.

MR. FRIEDMAN: In 8-1 capitalize H for Health. Group Model Health Maintenance.

JUDGE FADER: Well, Ms. Fader hasn't gone over these things yet. I told her she was going to have to go over these and what she said to me when she left this morning was, are you taking me to the Peppermill for dinner tonight? I said, yes, I am. Anything else before we discuss Gail's --

DR. FARAH: The original law. Did it read that appointments by the Secretary after consultation with, or is it the same language as was used before?

JUDGE FADER: No, the original bill did not say upon consultation with advisory board because there's going to be no advisory board until the Secretary makes the appointments.

MS. KATZ: But the Secretary will consult

with these various societies.

JUDGE FADER: Yeah, consultants.

DR. FARAH: So it was written as a consultation with the societies?

JUDGE FADER: It says, after consultation with.

DR. FARAH: That's what that said, consultation with, not nominations from?

JUDGE FADER: That's correct.

DR. FARAH: So it's at the discretion. It may not include any of those if the law is written that way.

JUDGE FADER: Well, for the President of the Board of Pharmacy, he's not going to say, upon consultation with. He is going to call Don and say, who do you want?

DR. FARAH: I'm talking about the four physicians.

JUDGE FADER: He's not going to appoint anybody Don doesn't want there.

DR. FARAH: I was talking about the

physicians.

JUDGE FADER: The physicians you say -- okay, after consultation with. The physicians are after consultation with. The board people are not.

DR. FARAH: Okay. I was wondering whether it should be after consultation with, or nominations from.

JUDGE FADER: It says after consultation with. Anything else?

(No response.)

JUDGE FADER: All right. Gail, why don't you tell us what you want to as far as pain people.

MS. KATZ: Well, let me ask Gwenn to make a comment here. You know, maybe this is enough but it is a large board. I didn't count but I'm sure there are thirty people on this board.

JUDGE FADER: I said someplace -- twenty individuals.

MS. KATZ: Okay. So ten percent would be from a patient perspective unless -- Marcia, is it your professional opinion that the physicians who would be representing these various specialties, would their

perspective be the enhancement of pain care for patients or looking for addictive behavior?

I'm concerned about the balance and that's what I kind of need to hear from you. I mean, I'm not suggesting there should be five patients on the committee, but I am concerned about the issue.

DR. WOLF: Well, first of all, two things. It says the MedChi and the Maryland State Medical Society. Those are both the same thing.

DR. FARAH: No, it doesn't say and. It says the Maryland State Society. That's a description of the term.

DR. WOLF: Okay. All right. I think you are right in the sense that we are not necessarily going to focus it as much as, say, a pain patient would.

I think that we're also going to bring some judgment to the table, whether we think there's actually legitimacy to the pain patient, as opposed to whether they are depressed or something -- bipolar or other diagnoses.

So I don't think that we're going to be

quite as blatant in the sense of saying that everyone should have narcotics for whatever reason they think they need it for.

MS. KATZ: I don't think the pain patients are going to say that either.

DR. WOLF: Well, there are some that do. But at the same time I don't think you're going to get the "looking under the bedsheets" positions for stuff. I think you may get more of a balance but definitely with some clinical expertise with the patient.

MS. HERMAN: I was just wondering, who would you suggest to add if you do that.

MS. KATZ: I don't know. My job and your job is to represent those two patients with that perspective.

JUDGE FADER: Okay. But what she's saying is, should the number of patient representatives be raised from 2 to 3 or whatever? Okay.

DR. FARAH: Well, if you do that, you will have a 21 member board. One is a chair, so the chair is going to break a tie. So, from a numbers game, if I

add one and there's no other discipline, that one will jockey in one for his position, like the --

MS. KATZ: Dental Board.

DR. FARAH: -- like the Dental Board may want to have somebody there. I mean, this kind of thing. I was going to say private practice but then I forgot that they don't write prescriptions --

MS. KATZ: Dentists do.

DR. FARAH: But dentists do, and you may find out that you may need somebody because of over representation.

Frankly, from a patient's point of view, it's very hard for me to think that you don't already have -- I think the four physicians are more -- I think the lobbying is going to be more towards patient interest, safety and pain.

MS. ZOLTANI: I think it's important. It's not the quantity, it's the quality. I think having the two of you here is really great. I mean, this is ideal.

MS. KATZ: I think it's very important that

these names be submitted by the Maryland Pain Initiative and not just float in from whatever. That could be very political. And the Maryland Pain Initiative, you know, I feel confidence in that body and I'm glad that there is a professional association -- us kind of associated with the patients, much as there's a specialty board with a physician. I think that helps. I think there's comment down there.

JUDGE FADER: Yes.

MS. DEVARIS: Yes. I have a question about the wording. Do you want the board physicians and the one nurse practitioner to be experts in all these areas that you're mentioning, or do you want one in each area?

If you write it this way, you are going to require that the physician and the nurse, under 7, be proficient in pain management, substance abuse, and addiction treatment. Is that what you mean, or do you want "or"?

DR. WOLF: "Or."

JUDGE FADER: No. It says with expertise in

areas of --

DR. FARAH: In clinical practice.

JUDGE FADER: Yes, okay, in clinical practice. That's not going to say they have to have expertise in everything.

MS. DEVARIS: Okay.

JUDGE FADER: Otherwise you would insert a word in there -- with all of the following areas.

MS. DEVARIS: But as it's written now it does imply that. It should be "or".

MR. TAYLOR: It should be or, not an.

DR. FARAH: Remove the "and" after the first comma.

MS. DEVARIS: No, you put an "or" after abuse. Involve pain management, comma, substance abuse, or addiction treatment.

DR. FARAH: For physicians and one practitioner with expertise in clinical practice that involve pain management --

MS. BETHMAN: No, it's the first. Pain management or substance abuse and addiction treatment.

JUDGE FADER: How about and/or?

MR. TAYLOR: I don't think the legislation will do and/or.

MS. DEVARIS: No, they don't.

JUDGE FADER: They don't?

MS. DEVARIS: No.

JUDGE FADER: Then we'll put or.

MR. GANDHI: Another clarification. Should we specify one each from all of the societies, because it could be interpreted to mean all from one and none from the others.

DR. FARAH: That's right. See, that's my problem with after consultation with or nominations from. Because I feel that these organizations should provide nominations for them to select.

JUDGE FADER: I understand all of that. I'm just not so sure that, considering who the Secretary is, that we should limit the Secretary.

Suppose the Secretary came along and one person in one of these groups was so undesirable to him or her for some reason, he's just going to leave

that blank. All right. You have to have faith and trust in the Secretary because the Constitution says you need too.

So that's my position on that, that I have to assume the Secretary is going to do the right thing and that we're not going to say, one from each of these groups.

MR. TAYLOR: I have another question. We talk about composition of the board. We talk about chair. We talk duties. But unless I go to commentary in last year's bill, I still don't see anything about the term of members and/or vacancies.

JUDGE FADER: We are going to get to that, but composition is what we're talking about now.

DR. FARAH: Judge, I'm still very concerned about that.

JUDGE FADER: Well, then you can put it up for an amendment that you feel that one person should be selected from each of these --

DR. FARAH: Disciplines, yes.

JUDGE FADER: -- and see whether or not

everybody will go along with you or enough people --

MR. GANDHI: If the Secretary doesn't like that nominee or recommendation from the society, he could always reject and ask for other names.

DR. FARAH: Ask for more. Tell them I want three nominees from each society. So we're not limiting the number.

JUDGE FADER: All right. Why don't you word how you want it changed and suggest the change and then we'll see what we'll do.

DR. FARAH: After nominations from, instead of --

MS. HERMAN: What about a caregiver to be on the board?

JUDGE FADER: We've got to listen and let Ramsay get this out.

DR. FARAH: Four physicians and one nurse practitioner with expertise in clinical practice that involves pain, or substance abuse and addiction, appointed by the Secretary after nominations from.

MS. BETHMAN: Based on nominations from.

DR. FARAH: -- after nominations from. It doesn't limit the number of nominations. He may say, give me five people to choose from, you know.

JUDGE FADER: All right. Any discussion on this point?

MR. WAJDA: Can we go back to the "and."

DR. FARAH: Okay.

MR. WAJDA: I don't think we can strike the "and" because if you put the "or", that means you could have all five individuals with substance abuse and addiction experience, and none involving pain. So we need the "and" to cover all those areas. Do you get what I'm saying?

I think it is written correctly as it is, and I've been with the Secretary when the Secretary make these kinds of things, and he says have you got enough folks that cover all these areas. I mean, that's typically how it is done. So I think when Judge Fader said that it would have to say all areas of practice, that mean the person had to have each one of them.

JUDGE FADER: Yeah, and I don't see it coming that way.

MR. WAJDA: I don't either. I don't think it can be "or."

MS. DEVARIS: I think it can be written more differently and be more explicit that you want somebody from pain management, that you want somebody from substance abuse and addiction.

JUDGE FADER: All right. But here is what Ramsay is saying now. His amendment takes care of that by saying, upon nomination from. What do you think? Can we have any discussion on that point?

(No response.)

JUDGE FADER: Okay. Can we have a motion to substitute that?

DR. FARAH: I would like to present this motion.

JUDGE FADER: Okay. Anybody second it?

MS. BETHMAN: I'll second it.

JUDGE FADER: All right. All in favor of Ramsay's suggested change, upon nominations from, raise

your right hand.

MS. DEVARIS: Could you read it? I don't know what I'm voting for.

DR. FARAH: Yes. Four physicians and one nurse practitioner with expertise in clinical practice that involves pain management or substance abuse and addiction treatment, appointed by the Secretary after nominations from:

1. The Medical Society,

2. The Maryland Physical Medicine Rehab Society,

3. The Maryland Society of Anesthesiologists,

4. The Maryland Society of Addiction Medicine.

That's it. And then, of course, and separately the nurse practitioner.

JUDGE FADER: Okay. So it's not upon consultation with, it's after nominations from.

All right. All in favor raise your right hand. One, two, three, four, five, six, seven,

eight, nine, ten, eleven.

All opposed? It's unanimous. That change will be made. Anything else upon consultation on composition of the advisory board?

MS. STAHR: I think it's 21 total numbers rather than 20.

DR. FARAH: Did you count 21? Yeah, we are 21, that's correct, because we forgot to count the nurse practitioner as one. So there are 21 people here, so the board is --

MS. KATZ: Without changing the number of pain --

DR. FARAH: -- there are 21 because I forgot to count the nurse practitioner.

JUDGE FADER: All right. So you want to make the four pharmacists also upon nomination from?

MR. TAYLOR: I think the same terminology will work there.

JUDGE FADER: All right. Don makes a motion for the same terminology. Is there a second?

MR. FRIEDMAN: I'll second.

JUDGE FADER: All right. All in favor? All opposed? That's it, changed. Anything else with regard to composition of the advisory board? Going once --

MS. KATZ: Gwenn.

MS. HERMAN: I just had an idea of a caregiver because those are the people who really are aware of what's going on, and a lot of times when the pain patient can't talk for themselves, the caregiver comes and is at meetings and understands what's happening in the family.

JUDGE FADER: Who would nominate the caregiver, Gwenn? From what organization?

MS. HERMAN: We could either do the Maryland Pain Initiative or it could be the American Pain Foundation.

DR. WOLF: There's a caregiver society. They just gave out an award to somebody down in Columbia. There's some kind of thing for caregivers.

JUDGE FADER: But couldn't they be part and parcel of a nomination from the pain society?

MS. KATZ: That would concern me because then you could end up with one patient and one caregiver and that makes me uneasy.

DR. FARAH: I think we have enough providers in there.

JUDGE FADER: All right. Well, Gwenn, do you want to make a nomination to that effect? I mean, amendment.

MS. HERMAN: Well, I don't want to take away two pain patients. Is it just that you can't add anymore people?

DR. FARAH: There's too many people.

JUDGE FADER: You can if people agree that you can. We have 21 now. Do you want to make that we add a caregiver?

MS. HERMAN: I would do it, yes.

JUDGE FADER: All right. Any second to that?

MS. DEVARIS: I second it.

JUDGE FADER: Second. All in favor?

DR. FARAH: No, hold on. Discussion.

DR. MARTIN-DAVIS: Discussion.

JUDGE FADER: Discussion. Please excuse me, I'm sorry.

DR. MARTIN-DAVIS: My question is, what -- I guess I'm still not sure what a caregiver would add that a pain patient would not.

DR. FARAH: Exactly -- the prescription monitoring program.

MS. KATZ: Well, there are cases where patients really are so physically debilitated they really can't speak for themselves, and the caregiver can be --

DR. MARTIN-DAVIS: But we're not talking about cancer patients that don't get enough medication. We're talking about diversion and --

MS. KATZ: Okay.

DR. WOLF: I treat those kinds of patients that you're talking about and we worry about the caregiver stealing their medication.

DR. MARTIN-DAVIS: Exactly.

MS. HERMAN: But that's a minority. That's almost like saying all pain patients are addicts.

DR. WOLF: No. For the most part, they are patients that don't have family members as their caregivers.

MS. DEVARIS: I just feel that the board is very heavy on professionals, and I think having a non-layperson is always a valuable adjunct to a group like this. And they do bring a different perspective than a patient to the board. I just think it's --

MS. BETHMAN: Should we increase this number here rather than --

MS. DEVARIS: Yeah. It would be a different category.

MS. HERMAN: Yeah, it would be a different category.

MS. BETHMAN: Well, rather than a different category, I'm just saying could you just increase the representatives of number 13 to three. It doesn't say patients. It says people who represent --

DR. MARTIN-DAVIS: -- the perspective of pain patients.

MS. BETHMAN: I'm just worried that it's

going to look like this -- that it's going to be harder to swallow for the legislature if we keep adding. We're already at 21. I mean, I guess the number will go up. You're right. We have four physicians, four pharmacists. Why not three?

MS. DEVARIS: It's pretty heavy --

DR. MARTIN-DAVIS: Right. But I think the professionals are the ones with the licenses on the line. That's my issue. So that's why it is so heavily leaning towards professionals, because we're the ones that take the hit if somebody does something wrong.

JUDGE FADER: LaRai, you're sitting back there. I almost lost you, kid. What do you want to say about that?

MR. EVERETT: In my experience, if there's somebody that really wants to be a part of the board, maybe they won't be able to be on the board but can come in as the setting as we're in now, and be able to propose their perspective as to why or why not they believe something should or should not be done.

DR. WOLF: An invited guest.

MR. EVERETT: In addition to that, it doesn't have to be made but would always be open to the possibility.

DR. FARAH: I stand up for this woman.

MR. EVERETT: Thank you.

DR. MARTIN-DAVIS: Will the advisory board meetings be open to the public?

JUDGE FADER: Everything is open to the public.

DR. MARTIN-DAVIS: Okay. So then, there you go.

JUDGE FADER: Unless the legislature says that something is confidential, and in my opinion they say too much is confidential, but that's just an editorialization. Everything is open to the public.

MS. HERMAN: But I would just say just from your reaction, Nicole, that because it was so strong about your license is on the line, that's even more why we need other people on the board to keep it even.

Because, even though you don't see the value of a caregiver, I mean, they do so much. They

understand everything that's going on in the medical system, because they've been through every route. They just bring a whole, completely different perspective.

The pain patient has a lot to lose also from this. I mean, if there going to be called drug addicts, they are not going to be able to get their pain medicine and that's just as bad as somebody losing their license. I mean, it's got to be balanced.

DR. MARTIN-DAVIS: Yeah. I would say that if it is an open meeting, that they would be invited to come and voice their opinions or voice their concerns. But I don't know that we need to put another person on the committee.

MR. KOZLOWSKI: Can I ask you clinicians a question? Why does there need to be FOUR physicians and four pharmacists? I mean, it's like -- are there four quadrants to the state and you all practice differently?

JUDGE FADER: Now, your next question is why

did Fader put four in there? Because that's --

MR. KOZLOWSKI: If you did, sir, I withdraw my question.

JUDGE FADER: Because that's what the 2006 legislation read. Period. That's the only reason I did that.

DR. WOLF: Because we come from very different perspectives often.

DR. MARTIN-DAVIS: And different training.

DR. FARAH: Exactly.

MS. DEVARIS: You're actually going to have five physicians and five pharmacists by the time you have the appointed board's appointments because they are made up of professionals. They are not going to appoint a consumer member.

We have consumer members on our board and we find them a really valuable adjunct to the board's deliberations. That's why I am very enthusiastic about consumer representation. In this case, the patient or the patient caregiver.

DR. FARAH: And the other reason is because

we would like to have this law pass this time.

MS. DEVARIS: Right. Well, it brings a perspective that we, as professionals, often don't have. I'm not worried about putting our license on the line. I want to hear from the people that we're serving and I think that's important.

MS. KATZ: We want to hear from the caregiver who has to jump through 10,000 hoops.

JUDGE FADER: All right. Now, just a second now. I have got to get through this caregiver -- very important vote first before I go to exterminating physicians and pharmacists. So let's go as far as the caregivers.

MS. KATZ: The caregiver. The perspective of the caregiver that I think we will not have without the caregiver is, I'm going to pick up my daughter's prescriptions. Her name is different than mine. I don't have any ID that shows that she is my 35-year-old child who can't come and pick up her own scripts for whatever reasons, and the hoops that I would have to go through -- it is a very complicated process, besides

which, I'm her caregiver.

I'm seeing that she's not getting sufficient care -- God forbid, my daughter is fine but she wasn't when she had her first child, and we had a horrible six weeks. Horrible.

I did have really dramatic problems in making the system work to support her. You know, I was taking care of a newborn, I was taking care of her, and the system wasn't taking care of her.

So, you know, I know that a caregiver can talk about things that might explain why five pharmacies were involved. You know, well, I was picking up the carpool so I went to the Rite Aid that was right there, and then I had to go get the groceries because we can only get certain things she needs at some Giant in Shleckyville and I had to fill the other prescription there.

Well, you know, that's a perspective that a physician isn't necessarily going to have. So I would suggest that we take the two to three, and be suggestive in the language that in respect to pain

patients and caregivers be included.

JUDGE FADER: Any other discussion? Hearing no other discussion, Gwenn has made a proposed amendment for including this, and we have a second. I ask for a vote. All in favor, please raise your right hand. Seven, really.

Okay. All opposed? Two.

MS. BETHMAN: No, three. LaRai.

JUDGE FADER: Well, LaRai, what did you say?

MS. FORREST: Opposed.

JUDGE FADER: Okay. All right. Well, we're going to say, you know, a lot of people are not voting on this but it did pass with the abstentions and we'll change the language to, nominated three people by the --

MR. EVERETT: Judge, one of the other things that they said earlier was that there was 21 people. Now you have 22 people.

JUDGE FADER: Yeah.

MR. EVERETT: So you maybe --

MS. BETHMAN: I'm going to bring it back down

to 21.

JUDGE FADER: Are you talking about the caregiver?

MS. BETHMAN: No, no.

JUDGE FADER: Just a second now. So, therefore, what I would propose then is we say three Maryland citizens, one of pain initiative, one of whom should be a caregiver.

MS. KATZ: But all appointed --

JUDGE FADER: Right. All nominated. All right. Okay, now pharmacists. And, of course, we're back to this Fader position that all these people should get paid for what they are doing. I just can't continue to see how you can ask all of these people to be working for these boards, taking time out of busy practices and not being paid. But that's not the time to be talking about this, I guess, because nobody has any money. Linda.

MS. BETHMAN: Yes, just a point of clarification. The Attorney General, or the AG's designee, the group will have counsel.

The AG's office represents the state constitutionally, but as far as being an actual appointed member on the board, it was the same issue that I discussed about the professional technical committee that wanted the AG as a lawyer for legal advice. They will be available for legal advice but they are not a member, per se, of the board.

That was a concern, thank you, that Linda Stahr pointed out in just the drafting of this. There will be advice from the Attorney General's office, as they are with all units of the agency.

MS. KATZ: Adjunct.

MS. BETHMAN: It's not an adjunct. We are there to serve the state agency. We are counsel, as we are to any unit of the state. But we're not a member. We don't vote. We're not actually a member of the board.

DR. FARAH: Actually, each one of our boards have that executive position but they don't vote on issues.

MS. BETHMAN: That's right. Well, we're not

members of the board.

JUDGE FADER: But, Linda, I don't understand what you're saying. Do you want to strike out the Attorney General or the Attorney General's designee?

MR. FRIEDMAN: And just put a footnote to that.

JUDGE FADER: Okay.

MS. BETHMAN: They will be advised by the Attorney General's office, as with any other unit of the state.

MS. KATZ: Do you even have to say that if it's a given for anything?

MS. BETHMAN: No, not really.

MS. KATZ: Okay. Then leave it out.

MS. KUHN: Unless there is a reason for us to be on the board.

JUDGE FADER: Let me speak against that. You have a specialized committee here with the Attorney General appointing someone who has expertise gathered with regard to this, separate and apart, perhaps, from the Chinese wall of advice.

MS. BETHMAN: Right.

JUDGE FADER: And I am not so sure that it is the best thing to do to take away the Attorney General's nominee. That's all I want to say.

MS. BETHMAN: Right. And that's fine if this body feels that -- and I can go either way -- but if this body feels that in and of itself in our role as being an Attorney General, the Attorney General's office for this state, we have something to add to the issue of diversion and abuse, that's fine.

But we will be there to provide legal advice anyway, as I counsel the board of Pharmacy, as I counsel any unit of the state, the AG's office will be available to provide that advice.

JUDGE FADER: But you have specialists within the Attorney General's office. People that specialize in surgeon fields. I mean, you and I have had a conversation this week where we're talking about subpoena power for the boards and things.

MS. BETHMAN: But the Attorney General's office would be there to provide that advice.

JUDGE FADER: I understand all of that.

MR. WAJDA: This makes an actual permanent voting member.

MS. BETHMAN: Yes, which is very different, exactly, than what we traditionally serve for our state agencies. So I just want, for point of clarification, to put that out there.

MS. DEVARIS: Yeah. I am concerned that there would be somebody from the AG's office who normally functions as an advisory capacity to all of the boards and professions, now being made a voting member of a board.

You can put in provisions that the Office of the Attorney General will provide counsel or the board, and that would be different than voting membership on the board.

I think you really are crossing that Chinese wall when you put them in the position of voting for something rather than advising us, as they normally do, and that is their position.

JUDGE FADER: All right. Now, once again, is

there any other discussion on this point? All right. So, Linda, are you making a motion that there be an amendment that the Attorney General be removed from having a voting position on the board, to a footnote position that the Attorney General will be there to give advice?

MS. BETHMAN: Absolutely, yes.

MS. DEVARIS: I second it.

JUDGE FADER: All in favor, raise your right hand? Ten.

All opposed? That's it.

DR. FARAH: And that really resolves the 21 number issue.

DR. WOLF: Wait a minute. Were we going to put some kind of footnote wording to preempt the dentists and the veterinarians, or did we decide we didn't want to open that can of worms?

DR. FARAH: Well, if they come pounding on our door and asking for it, we'll worry about it. Besides, I don't know why we want to have the veterinarians.

DR. WOLF: But, I mean, did we want to say something to the effect that we considered it and decided it doesn't --

JUDGE FADER: Yes. I'll put a footnote, no dentists, no vets.

MS. HERMAN: You're not married to a dentist, so I'm going to take this one home.

JUDGE FADER: Okay. Anything else with regard to composition of the advisory board?

(No response.)

JUDGE FADER: Hearing none, that issue is closed.

Number two. All right. The Secretary shall designate the chair of the board, that's a must. I hope everybody agrees.

All right. Now, we have two other issues. The duties of the advisory board --

DR. FARAH: I'm sorry. Are you on the second -- not elected amongst the advisory board members?

JUDGE FADER: Unless somebody wants to make a

nomination that they be elected, which I don't think the legislature is going to go for, but that's up to you. All right.

MS. HERMAN: Can we make sure it's a judge?

JUDGE FADER: No, you can't. I take it you don't want to make that nomination, Ramsay?

DR. FARAH: No, I was just asking because I was just thinking of other boards and -- no, I don't specifically feel one way or another.

JUDGE FADER: Okay. That's fine.

Now, we have duties of the advisory board and then we are going to get to Don's point about terms. All right.

So, duties of the advisory board. We're going to discuss this now and I'd ask you to please read this. I did send you this Exhibit C, the people that mandate the use and work with the Advisory Council. There's an awful lot of them.

DR. FARAH: How are we going to reword number 6, comments?

JUDGE FADER: We're going to take it out.

DR. FARAH: You're going to footnote it somehow, right?

MS. KATZ: Weren't impact drugs in here someplace else?

JUDGE FADER: No. The impact drugs were in with regard to --

MS. KATZ: They are in the last paragraph.

JUDGE FADER: -- Recommendation No. 1 would just take this and six completely out.

MS. KATZ: Right. But they reoccur right below it.

DR. FARAH: That's why I was wondering whether you wanted to footnote it somehow.

MS. KATZ: See if there's another recommendation --

DR. FARAH: You can put it as a -- that should be considered to be included as part of the drug. You can leave it in but remove the other part and keep the footnote.

JUDGE FADER: We will.

DR. FARAH: This way it gives an opportunity

in the future to bring it up, but it doesn't mean it's going to be done.

JUDGE FADER: That's fine.

MS. KATZ: In number four, I'm just not sure how the PDM data is going to show the impact of the program where patients access the pharmaceutical care.

DR. FARAH: One of the papers I attended, I think it was the guy who handled the New York piece, was showing how the number of prescriptions of opiates were changing with time. They had logged in a number of prescriptions.

It's really fascinating, because he was showing like there was about 20 percent reduction over the period of time he was showing in actual writing of pain medication prescriptions. So I think it's of interest for many reasons, because unless you look at other data you don't know what that means.

MS. KATZ: You.

DR. FARAH: Exactly. It could be that it has a chilling effect, as one of the concerns we have had, or it could be something good that people now have no

business prescribing and now know better than to do that.

But then again, it could be trending because of changes -- I mean, there's so many different things. So, there are ways of looking at it and that's why I wanted the technical group so that they can look at data and say an explanation of what it means and where we're going with it --

MS. KATZ: Okay. All right.

DR. FARAH: -- you know, this kind of stuff. So we just don't throw numbers out there without somebody from legal looking at it.

MS. KATZ: But those are the kinds of things that we need to structure as our goals and objectives so that those can be our evaluative criteria, and we have to have them here, written before we begin the process.

JUDGE FADER: Is there anyone who needs any more time to continue reading? This was something we kind of sent to you before.

All right. Are there any suggestions for

corrections, modifications, subtractions, additions, anything else to these materials? If so, I would ask somebody to speak up. Mary, you have something you want to say about this?

MS. JOHNSON-ROCHEE: I was just looking at paragraph six.

JUDGE FADER: Paragraph what?

MS. JOHNSON-ROCHEE: Six.

JUDGE FADER: Yeah, we just said we're going to take that out, but put a footnote that indicates that for the future if -- it would be thought that if other drugs would be added by the Secretary, that the advisory group would make some recommendations with that regard. Anything else?

DR. FARAH: I have a quick question. Under commentary, you put the previous bill. Is this just more as a reference point? Is that why you put that in there?

JUDGE FADER: Well, Linda can tell you whether I'm correct about this or not. Both Lindas can.

But when the legislature has given so much consideration to something previous, and have been comfortable with that going through the legislative committees and things of that sort, in my opinion. They want to see what they have done previously and analyze that against what they're being asked to do now.

I don't know whether I'm exactly correct about that. I haven't talked to every member of the legislature. But the ones that I've run with in Baltimore County and everything have pretty much told me that. That want to see, or like to see that, so that's the reason I did this. Linda Bethman.

MS. BETHMAN: I think it's a good reference point. We're not straying too far from it. Is that helpful? Are you worried about that?

JUDGE FADER: Linda Stahr.

MS. STAHR: I think we should consider whatever you recommend.

DR. FARAH: I have a concern because if we're not going to be all-inclusive, we may have a problem.

We're referencing a segment which, essentially, I personally had a problem with before because it didn't include the modifications we had for this advisory council.

JUDGE FADER: But I have all of these segments throughout here for the 2006 and Bill 1287 and also to other legislation.

DR. FARAH: Can we put then -- maybe add here the piece of the addition that occurred from the development of this board as a reference point because the Maryland Society of Addiction Medicine has a special slot appointed for this advisory board, which didn't exist in this piece of legislation.

So, at least to balance it out so it doesn't look like this is okay, and what we're doing is in addition, when already we have the presence of that addition by having the side represented on this advisory board.

JUDGE FADER: I could do that. I'll put it right after 21-2A-03, please note. Anything else?

Needless to say, this is a big-ticket item

so I want everybody to tell me that they've pretty much finished reading and don't have any other comments before I move off of this.

MR. TAYLOR: I guess I'd go back to number four. As mentioned before, the term "patient access to pharmaceutical care." I'm not sure this program is going to do anything to patient access as far as a measurable outcome. We might use the term "provision of pharmaceutical care" or something.

JUDGE FADER: See, I think patient access to pharmaceutical care -- if I can just comment on this -- is very, very important here.

There are so many people who are in the mode of pain who will tell you that they want someone to listen to them because of all the physicians in the world that are not prescribing the medication that they should because of fear of Georgette and Mary and lawsuits. That's when I reincorporated this here. That's what went through my mind.

The pain physician, the pain people, are very, very concerned about this, that they are not

getting proper access and not proper direction to people who could help them.

MR. TAYLOR: Perhaps we should put in there prescribing.

MS. DEVARIS: How would you get that information from prescriptions, that people are not getting what they need?

JUDGE FADER: I asked Gwenn and I've asked Gail, is there any documentation, any statistics, anywhere, anyplace, anytime, to support the thought processes that there are too many physicians out there that are not properly prescribing to relieve their pain. They have said that there's nothing there.

MS. KATZ: Well, the only thing that does exists, I think --

JUDGE FADER: There's a perception.

MS. KATZ: -- is in nursing homes. Isn't there --

DR. WOLF: There is data.

MS. KATZ: There is data that shows that there is under-prescription for pain, particularly in

nursing home populations. I don't know anything beyond that, but I hope you do.

DR. WOLF: There's data, but there's also data that showed that patients themselves in the hospital -- at least acute data -- that patients will pick and choose how much analgesic they want based on the side effects that either they perceive they are going to have or that they are actually having. So the patients will actually voluntarily under-medicate themselves under certain circumstances.

MS. DEVARIS: Okay. So you would be using an external source then, other than the prescription monitoring, to obtain that information?

JUDGE FADER: I'm just asking that the advisory board ready itself for a voice, for people from the outside, to talk about this. That's the reason I felt that the legislature put it in the first bill and that's the reason, when I looked it over, I incorporated it in this draft. But, I mean, that's up to you.

DR. FARAH: I like the idea. I honestly like

the idea because it gives us a why of thinking, looking at information, looking at data, see how it is that you can safeguard, if we have, and as technology advances. We may be able to find, for example. sitting here brainstorming how we can do the programming -- I like this idea.

MS. KATZ: Right. I couldn't agree with you more. I think that we need to say, a focus of this board is assist patients, to protect patients, to enhance their pain management.

JUDGE FADER: Right. Particularly when the legislature directed us to.

MS. KATZ: This does give balance. Now, how it is going to be done -- and right now the only data I can think of is pretty gross. You know, it's the number of prescriptions. But I'm hopeful that the technology people will be able to show ways to data -- whatever crazy word you used before, not mined but --

DR. WOLF: Dredged.

MS. KATZ: But, in any case, to use the data in ways that will help us see. You know, maybe by

tying patients to diagnosis codes, or God knows what. I mean, there may be other things that we will be able to do way down the line.

MS. DEVARIS: I think it's a good goal, but you're going to have to defend how you're going to get the information because I can't see just monitoring prescriptions is providing that kind of information.

MS. KATZ: No, you're right.

MS. DEVARIS: Things like your JCAHO reports may have that, because they do look at pain control when they come around and survey at the facilities.

JUDGE FADER: JCAHO is the Joint Commission on Accreditation of Hospitals.

MS. KATZ: And they effectively are the licensing agency for every hospital in the state.

MS. DEVARIS: It's another name now. It's health care facilities now. It used to be just hospitals.

DR. WOLF: There's also data -- there's surveys out there that have been done for patients that have gone home, whether they've gone home with adequate

analgesia either post-operatively from the emergency room, and there are various studies that show various things. Not just hospital-based data but there's also community based.

DR. FARAH: I can see how looking at global numbers and distributions, how we can request grants to do some studies based on overall information and flow that could address this kind of an issue.

If we see a certain pattern in certain areas, I can see writing up a grant to request some more accountability to go further into getting this kind of a thing. SO, I think it's good.

JUDGE FADER: Anything else then, please? Bruce.

MR. KOZLOWSKI: Nope.

JUDGE FADER: Anything coming up the line? Anything? Okay. Come up this side.

MR. TAYLOR: I just have one more question, just for clarification, on number five. We said, provide ongoing advice and consultation on the program, basically. But then we specifically said including.

I was just wondering why we specifically put the two inclusions. I would think we would want the advice and consultation on the implementation and operation of the entire program. I'm not quite sure why we picked out two things to specify.

JUDGE FADER: I just felt that these sentences here took in everything. The design and implementation of an ongoing evaluation component, changes in the law to reflect, provide ongoing advice, consultation for the operation. I just --

MR. TAYLOR: I thought that was all inclusive, basically.

JUDGE FADER: Well, the situation is that somebody was talking about technology. Somebody else was talking about evaluation. So, I just lifted those things.

MS. KUHN: Can I address that a little bit? That including, in the legal sense, isn't a limit. So including, you're just saying we really want you to make sure you do these things. It doesn't limit you to only those things.

JUDGE FADER: Yeah, the Court of Appeals keeps saying time and time again that when you say including, that means it's not only this stuff, it's everything plus this stuff.

MS. DEVARIS: You could also put not including, but not limited in there. That's commonly written into the statutes.

JUDGE FADER: You can do that, too, but the appellate court opinions are that that's really not necessary.

MS. BETHMAN: I guess John's question was why highlighting these two, but you've answered that.

DR. FARAH: Can you fix the typo then? The and -- and best practices in the field.

JUDGE FADER: Okay. Devang, anything else? Okay.

Mrs. Fader will read all of these things. Thanks for calling the attention to all of them. There's nothing like an Idaho schoolgirl. Yes.

MR. CLARK: Did we address the terms?

JUDGE FADER: No, we're not to that

situation. Al, anything? Gail?

MS. KATZ: I'm good.

JUDGE FADER: Georgette, Ramsay, Marcia -- Marcia, who is there behind you?

DR. WOLF: Linda.

JUDGE FADER: Linda Bethman, anything else?

MS. BETHMAN: No.

JUDGE FADER: Okay. Anything else? LaRai?

MR. EVERETT: I'm good.

JUDGE FADER: Police?

MR. MOONEY: Good.

JUDGE FADER: Term limits?

DR. FARAH: Four years.

JUDGE FADER: I don't know. I kind of thought if I was the Secretary of Health and Mental Hygiene, I would want people to serve at my pleasure so I left it out, but that's up to you.

DR. FARAH: Serve for a period of four years with renewal times one.

JUDGE FADER: That's what you want to do, but, I mean, I kind of thought -- I can only tell you I

left it out and the reason is I kind of thought that --

DR. WOLF: Is there any mechanism to replace someone that doesn't --

JUDGE FADER: Only if we put term limits.

DR. WOLF: No, I mean somebody that doesn't show up. I mean, there's somebody on this committee that hasn't --

JUDGE FADER: You can do all of that. If you leave it to the Secretary, you leave it the way it is, he or she serves at the beck and call of the Secretary, at their pleasure. Okay.

Now, if you want to change it, you have to put terms in there, you have to put vacancies. Right now you don't have to do anything.

DR. FARAH: The problem is that the Secretary is an appointee of the Governor. Governors change. Secretaries change. And the corporate memory of this group becomes critical if we want to do something positive and ongoing. I think it cuts down a little bit on the politics. Nobody stays forever. Four years with one term gives new blood to things. I mean,

that's just an opinion.

JUDGE FADER: Okay. Well, I'm telling you the reason that I just left it that way, and it's just up to Don or anyone else that wants to suggest that there be terms, and if there are, then we have statutory schemes in place to deal with the terms, to deal with what happens if there's a replacement or a vacancy. That will all plug in.

The reason I left it out was it just seemed to me that the capricious and arbitrary and whimsical decision of the Secretary should be enough.

MR. TAYLOR: My only concern was that there are times in the past where an entire board has been wiped out in one term based on political --

Whatever the basis is, an entire board has just been totally wiped out. And I think that there should be terms and they should be staggered so that you have continuity and so the people know what's been done and how the committee is working.

JUDGE FADER: Bruce?

MR. KOZLOWSKI: The committee is advisory to

the Secretary, so all that other stuff is irrelevant. It is advisory to the Secretary. If the Secretary does not feel comfortable with the people that are there, your term limits are of no value at all. I think the judge takes the most appropriate approach in this and leave it to the discretion of the Secretary.

DR. FARAH: Excuse me. The alternative would be that they couldn't be. That it's set by legislation. It's an independent commission working on its own under the Department of Mental Health and Hygiene, or under the Bureau of Justice for a fiscal --

MR. KOZLOWSKI: I don't think I'll see that in my lifetime.

DR. FARAH: -- I'm saying the alternative. There is an answer to that.

MR. KOZLOWSKI: I understand there is.

DR. FARAH: So we're putting in an advisory because it makes sense in the present world of how we get something up and going because you want to make it work.

MR. KOZLOWSKI: Right.

DR. FARAH: But the reality is, there is a purpose for this board, and the purpose of this board is to do this mandate. And it should not be at the whim of a political change in a situation. We have a technical function that we are supposed to --

MR. KOZLOWSKI: Reread the mandate. The mandate says to advise the Secretary. That's the mandate. The rest of that whole piece of legislation is authority of the Secretary to do X,Y, and Z. It still rests with the Secretary. The advisory committee is nothing but advisory. You go beyond that, it's not going to happen anyway.

JUDGE FADER: Okay. Now, if there's no other discussion, then I've got to ask for a proposed amendment and a second and see what we what to do with that. I mean, it's up to you.

MS. KATZ: Haven't we, by suggesting how these people are nominated, haven't we done a lot to extract it from the political process?

DR. FARAH: I hope so, yes.

MS. KATZ: So I think maybe -- I think we should go with --

JUDGE FADER: Gail, you're a wise woman. There's nothing that's ever out of the political --

MS. KATZ: But, okay. So we would be a new administration's -- if there was a change in the administration -- going to the same boards, asking for nominations. And, yes, there may be different people but they would be still coming from the same specialty areas.

So it isn't going to be capricious if there were a change in administration. So I feel like -- I am concerned about the historic memory sort of disappearing if there was a wholesale replacement --

JUDGE FADER: Well, you're going to have a lot of minutes and things of that sort. Let's go to two years into the future when Chairman Everett is the chairman of this, and she's sitting there and two or three people aren't showing up at the advisory board and she calls them up and she says, Are you ever going to come? Well, we can't, we're doing this and doing

that, everything.

She's going to go to the Secretary and say, replace them, and he's going to say, Okay. That authority just exists. Who was it? De Gaulle said the graveyard is full of indispensable people. He didn't say much. All right, anything else? Any motions? Anything?

(No response.)

JUDGE FADER: Okay. Anything else with regard to this? Now, I'm not asking, because I have a lot of reserve, as you can see. But just to get a finger on this, when is lunch coming?

DR. WOLF: Between 12:00 and 12:30.

JUDGE FADER: Okay. All right. Can I move ahead to No. 7, which I think we can get out of the way pretty easy. Patient Access to the Base.

Anybody really have any objection to the patients having access to the base? The way that this is formulated is that they can make suggestions that have to be recorded, but that they can't change any of the information. Anybody?

DR. FARAH: I think how they have the access is more critical than having the access and I think we need to address that.

JUDGE FADER: Well, in all of these things that are online, through regulations, there have been adopted forms for access where a patient may fill out a form and get online and find out what the situation is.

MR. SHARP: Judge, I have a question. Does patient include a patient's designee?

JUDGE FADER: If it's a legal designee.

MR. SHARP: It does include that?

JUDGE FADER: Yeah.

DR. MARTIN-DAVIS: Okay. So when you say patient, you mean I have a patient in my office and that patient can pull up their account?

JUDGE FADER: Anyone whose name is in the database. No, they can't pull up their own account. They must go to the Secretary. They must fill out a form. They must send that in, and then the information is supplied.

MS. KATZ: So they don't have direct access?

JUDGE FADER: No. Nobody has ever given a patient direct access.

DR. FARAH: Okay. That's what my concern was.

MS. BETHMAN: They'll get a report.

MS. KATZ: I'm comfortable with that because I can see people sitting in a public library pulling up their record.

JUDGE FADER: As a matter of fact, a couple of the websites say that the information will usually be mailed to you in one or two days.

DR. MARTIN-DAVIS: So just on request they go through the steps, they fill out --

JUDGE FADER: Same as the Medical Records Act of the State of Maryland.

If you want to see what your records in the pharmacy are, including the comments of the pharmacist whose comments concerning you are in the database, you have a right to request that. The pharmacy has to present that information. And if you see in there that everybody feels that Nicole is a

hypochondriac, and things of that sort, you have a right to submit information and say this is stupid, this is crazy, the answer is no, or I'm not allergic to sulphur or anything of that sort. But the record cannot be changed. Your comments are just included.

DR. FARAH: But I think definitely it should be a user fee if this is going to happen. Yes. Absolutely. Just like medical records. You pay to get a copy of your records and it's in the law. There's a fee to pay if you want to get a copy of the record, and we're looking at how we're going to get money.

JUDGE FADER: This is what I said as far as consistent with the provisions of the Maryland Confidentiality and Medical Records Act because all of that contains information as to the costs and it seems to me that there really have not been that many problems with that.

Any questions? Any comments?

DR. FARAH: Can you imagine one million copies that you have to send? Who is going to pay for that?

JUDGE FADER: But you don't have to do that anymore, Ramsay. You can charge the patient.

DR. FARAH: Okay. That's what I'm saying.

JUDGE FADER: This is what I said. The Maryland Confidentiality of Medical Record Act would click into play with regard to the costs and everything else that would be a concern.

MS. BETHMAN: Also, it's consistent with the PIA.

JUDGE FADER: What's PIA?

MS. BETHMAN: The Public Information Act. If you want to request a public record, you need to pay for the copy. So I don't think it's going --

MS. KATZ: All right. I'm good.

JUDGE FADER: Anything else in regard to that, No. 7? In other words, the patient can come in, can request. Patient does not have online access to their records. The Secretary furnishes it and all the cost of the procedures are consistent with the Confidentiality Act, and I'll add PIA because I forgot that until Linda said something about it.

All right. Nobody eats until they vote yes.

MR. GANDHI: Judge, on page two. HIPPA should be HIPAA.

JUDGE FADER: Mrs. Fader would have picked that up, too. All right. Anything else?

Dispensers. No. 3. There really wasn't much as far as changes with regard to this, but there are a few important changes with regard to the commentary.

The Maryland Nurses Association has given us their opinion and statements with regard to their testimony before the legislature. Delora Sanchez, et cetera, and Michael Souranis, who is a member of the Maryland Board of Pharmacy, questions that and says that he doesn't see that their data is supported by facts for institutional pharmacists. So outside of that, we'll read that and then ask any comments. Yes.

MR. TAYLOR: The only question I have reading through this is everywhere we talk about pharmacies.

We don't talk about dispensers. There is a lot of other places going to dispensing. Clinics, doctors' offices, et cetera, but the only thing we seem to talk about are pharmacists.

JUDGE FADER: All right. Here's the situation then. It says dispensers. And a physician cannot dispense, as Linda has told us and you have told us, unless they are specifically authorized to dispense. So they're covered.

MS. BETHMAN: I think --

JUDGE FADER: Whether Marcia opens up a practice of medicine, if she wants to dispense medication from her office, she has to specifically be -- is it licensed to do that, certified? What do you call it to do that?

MS. BETHMAN: They get a dispensing permit.

JUDGE FADER: -- dispensing permit to do that.

MR. TAYLOR: Well, if you read your first paragraph, it says that all pharmacies dispensing prescriptions to patients, and all practitioners. When

you read further down the only thing that's mentioned from there on down is pharmacies.

MS. BETHMAN: I think because we were addressing the inclusion of non-resident pharmacies, which are pharmacies, and certain inclusions of the institutional pharmacies.

JUDGE FADER: All right. I will review that to make sure, Don, because I may have screwed up on that. But your point is well taken. It should be all dispensers, people that are authorized. Okay.

MR. FRIEDMAN: I want to say pharmacies licensed in Maryland are licensed to dispense in Maryland, because that really -- that includes the non-resident pharmacies and I think we want to make that point.

JUDGE FADER: Linda did make that point.

MR. FRIEDMAN: Does it say in here non-resident?

MR. TAYLOR: Yes, the second paragraph essentially is dealing with that.

MR. FRIEDMAN: Okay. I've got it. I see.

JUDGE FADER: And thanks to Linda and the people that worked with her on that, that's in very good shape. So I'll --

MR. GANDHI: Judge, are we covering the federal agencies, V.A., official pharmacists?

JUDGE FADER: We don't have any authority to do that. If they dispense in-house, in the V.A., we have no control over them.

MS. BETHMAN: Although, Don, correct me if I'm wrong, a lot of the federal pharmacies are licensed anyway.

MR. TAYLOR: A lot of them are.

MS. BETHMAN: So if they choose to be licensed, then they are going to be covered.

MR. GANDHI: Okay.

MS. HART: A lot of them do report to the state.

JUDGE FADER: Okay. Any other comments? I do feel that we should leave in the commentary both the position and former testimony of the Maryland Nurses Association, plus the testimony of Michael, that he

doesn't feel that when they presented that information that they had any data to support, and then let the legislature do whatever they want with it.

DR. WOLF: All right. Lunch.

JUDGE FADER: All right. Then I'm going to say No. 3 is approved.

(Whereupon, a lunch break was taken at 12:30 p.m.)

(Back on the record at 12:45 p.m.)

JUDGE FADER: Now, we're going to No. 5. I'm going to skip over No. 4 for a minute because Bruce has a conference call that he has to get to and he wants to make sure he gets in on this.

Those of you who remember seeing Cabaret and Joel Grey singing Money, Money, Money will be able to relate to this in No. 5 a little bit better because what the legislature does, or doesn't do, is going to so much depend upon the fiscal note because we don't have any money and they have less money than we do.

The way I see this, subject to discussion, is three possible options. We wait for David Sharp and Bruce to get the assortment of federal and state funds to go through with the Health Information Exchange. I have no idea -- and I don't think they do either -- what's going to have happened although David said three to five years.

We go through the stand-alone funded system through Rogers, to whatever extent is possible, and Ramsay is going to talk to us, as well as Gail, about the funds that can be available there, not available.

And then Gail has brought up as a result of her meeting in San Diego the fact that some of the newer programs are licensing and borrowing software, such as McKesson software and things of that sort to implement programs, which means that a lot of foundation information is really not necessary to do. You just buy a system, such as Quicken, that is in place.

Now, I asked Frank Palumbo of the School of Pharmacy to see what he could find out about this

because he's Chair of the Drug and Policy Division, and he has not been able to get back to me with a complete report about what the McKesson system is all about, what is provides for, things of that sort, and whether it would be possible to get involved in any of this.

We certainly have Bob Lyles talking to us about using Surescripts and things of that sort, and trying to rent some software that's sufficient if it --

So with that we'll begin the discussion. Since Ramsay was the first one to send me something on this, I would ask that he talk about Option 2. And then, normally, I would say then we'll have questions, but with this one I'm going to say, then we'll have cross examination.

DR. FARAH: The Harold Rogers grant has essentially three phases to that approach. One is a grant which usually goes up to about $50,000 that allows organizations to explore whether they have any feasibility to do any such program. I think we've

applied for that and we are the recipients today of this.

JUDGE FADER: How much did we get?

DR. FARAH: About $50,000.

MS. ZOLTANI: 50 -- that was a planning grant is what I applied for and we got it.

DR. FARAH: The second grant is a grant which is designed for implementation. It goes up to $400,000. They do have some funds out of their funds that are assigned to that. It's a competitive issue. We have to put a bid for it. The committee usually takes certain things as a priority before they make the decision as to which state is going to get that grant.

From the several meetings that we have attended, it looks like we are, at this time, favored because we've already started the initiative on it and we would be getting into implementation with a little bit less other competing states for the same kind of money. So the timing is good. A few years ago it wouldn't have been good. A few years from now we don't know how much of that type of funding is

still going to be available as more states catch on.

We have up to $400,000. We would have to submit the grant in January. They will tell us in July whether we get the money or not, and if we get it, it will be available next October.

Of course, one of the contingencies will be that by the end of April that our legislation, and our Governor, would have accepted that we do have a program.

The third phase of the Harold Rogers program is they do have a grant that you can go in after. Usually it is a grant that is designed to enhance your program, or add new stuff into it, or focus or drill into some specific area that you want to improve more in that program. So you can go back for more.

That is going to be much more competitive because now you have almost 40, 50 states that are going to be vying for that. The amount would be less. I think the maximum they have given is like about 200,000 for that piece.

Another source of funding is an enhancement sort of funding from NASPER. They have about a couple of million and they give ten grants of $200,000 apiece. These are great for second year recipients of the Harold Rogers grant because that grant is designed to fine-tune and complement that first year of implementation.

JUDGE FADER: Now, who is this from?

MS. KATZ: NASPER. NASPER has been passed for many years, but this year it's been funded. It's never been funded before.

DR. FARAH: That's correct. So they have 2 million right now available.

MS. KATZ: And Harold Rogers has much more. They have 7 million.

DR. FARAH: They have 7 million.

MS. KATZ: And they've been funded for three years, four years, something like that.

DR. FARAH: Yeah, they've been okay. So the social funding for the first year is quite reasonable to get the implementation going.

The second year we have partial support and so we have to start thinking of how we're going to be able to raise enough funds to be able to have a second year of successful enterprise, and, of course, the third year you potentially have a very good chance of having additional support. So the first year and the second year, it's pretty much, I would say, a 95 percent chance that we can get that kind of funding.

Part of the thinking of how you're going to be able to get additional money would be to look at what is happening now and how we differ from other states. Other states, for example, do not have a controlled dangerous substance licensure or certification. So when they have to implement something, and they are going to put a user fee of some sort, they have to come up with that kind of money from the general funds in operation.

JUDGE FADER: In other words, our drug control is a big different entity because we have one that a lot of other states don't.

DR. FARAH: That's correct.

MS. KATZ: We have subtle licensing with the DEA and the state.

DR. FARAH: That's right. So the state, at one time, was toying with the idea of why do we have to have a duplicate certification. So there may be moves of, you know, if the DEA already has one, why does Maryland have to have a specific one?

Well, we're not the only state with only a specific one and now it makes much more sense of why we have a specific one, because now we can use that as a credentialing mechanism for people who want to use it. We can use it, of course, for tracking and it's a source of funding that can, in part, play a role with the prescription drug monitoring area.

So we have a little bit of support here from about 23,000 licensees that get their license in controlled dangerous substances.

Of course, there's a budget and the expense of things that need to be paid. However, it is not starting completely from scratch. I thought that in

addition to that, we can have a specific user fee for those who want to use it beyond a specific kind of access that needs to be done.

Other potential sources of income would be if anybody is charged, that there may be a special taxation or a special fine or special fee that can be appropriated to that as an automatic kind of a thing, or in some kind of criminal procedures like when you do drug seizures or what have you, that there might be some kind of a percentage appropriation that can be designed for this program.

So there are things that are grant contingent. There are things that can be put as a user fee. There are things that can be used from licensure, and things that could potentially be tapped if this program is really found viable and reasonable and good to have, that you can be creative in how to do it.

I know, for example, if the Board of Nursing or the Board of Medicine sanction somebody and they levy a fine, that that money goes to the

general fund. It doesn't go to that specific board. So in a situation like this, some fine or some levy or something whatever happens, then maybe one way to fund this program is some of these funds could be appropriated to this account.

So, in general, at this time a stand-alone program is considered that we can make it viable. It is conceivable to set it up in such a way that it can tie in, in the future, for anything we want it to do.

Remember, what you are going to be asking for is a program that is, basically, mostly a software housed in a location in a certain format. Now, the key is then to look at what the future formats are going to be and see, could we structure this in such a way that hopefully it will tie in with a future program.

Now, the interesting thing is that one of the Harold Rogers grants have been for years, the second round has very much been in taking programs that had challenges with their data, to be able to make it talk and consolidate with other data systems

because, as we all know, that technology is ever evolving, ever going on. My expectations are it's not a one-shot deal; it's continuously going to be changing.

So whether we stand alone, or whether we have the eye on the big game and try to make it a merge, no matter how you slice it, sooner or later this data issue is going to continually be changing and we need to be ready to push ourselves to that.

The advantage of stand-alone is, right now we know we have money that we can tap. We know we are favored. The atmosphere is ripe.

There is an lot of start-up thinking we have to do, a lot of planning and work, which is down time, so why appropriate a million dollars of funds from whatever when we don't even know how unsuccessful and all the intricacies and all the growing up pains we have to go through. We can use that research money or the grant money to be able to set us up there, and this way will be much more cost-effective when we transition to a generalized

data in the future, or we fine-tune it in the future.

So I feel that it is a good idea to have a stand-alone project now, which we can outsource if we don't want to do it in-house. There are several companies that deal with this, and we can negotiate in our contract such a way that the data that we are going to get is gathered in such a way that we can make it usable and functional in the future.

JUDGE FADER: LaRai, you indicated that you supported wholeheartedly Ramsay's view and I wonder if you want to say anything in addition to what he said.

MS. EVERETT: No, I think he covered it.

JUDGE FADER: Okay. Peter Cohen also has a comment in here with regard to this. He said, he's assuming that they would have an ease of talking to other databases, and I'm sure we're going to hear a little bit more about that.

So, Gail, is there anything you want to say with regard to this?

MS. KATZ: Just a couple of things. I am very concerned about spending a lot of money on

something that is going to be obsolete in the very foreseeable future, possibly before it's actually up and running.

I think that we are in an extraordinarily advantageous position for a lot of reasons. One being that I don't think we'll have a problem getting a Harold Rogers grant, but the other being that 40 states now have these PDMs up and running. I think if we could --

MS. ZOLTANI: Only 33.

MS. KATZ: 33, all right. But there are a lot of them up and running. A lot of mistakes have been made. I think that there are 33 databases that could be looked at from a standpoint of what Maryland is planning, looking at the ones that might provide us with the greatest possibility of that translation, of that ability to move into the larger system.

The other thing that I just wanted to say, since the Judge brought it up, I was approached by somebody from McKesson who is involved with a database that they have for their own proprietary

purposes. McKesson is a pharmacy management --

DR. WOLF: It's a wholesaler. Distributor.

MS. KATZ: A wholesaler. And they basically keep track of virtually -- he told me close to 90 percent of every prescription that's written. Not just their prescriptions. They are like a Surescripts in the sense that they try to get a very universal picture.

He told me that two states, Mississippi and maybe Oklahoma -- please don't quote me -- use their, it's called RelayHealth, as their PDM, and McKesson charges each of those states approximately $135,000 a year usage fee.

So, you know, to me, on the face of it it sounded too good to be true. It probably is. I have tried to get back in touch with him to ask him some questions, and I guess he went away for Thanksgiving and he hasn't come back because he hasn't responded. But, that is out there, and should he respond to me, possibly he can answer some questions.

JUDGE FADER: He did send you this --

MS. KATZ: He sent that before I asked him specific questions.

JUDGE FADER: Yeah, this RelayHealth, which is on the back here.

MS. KATZ: Right. I don't know how useful it truly is. You know, who can access it, I don't know any of it. But I know about it, and I felt that everyone should know about it.

JUDGE FADER: Well, Mary, I don't think Barack Obama has any more money than the rest of us with this federal system that he wants to get started, but what do you think about any of this with regard to Ramsay's point of view?

MS. JOHNSON-ROCHEE: It sounds like I think we are in a good position to -- at this time, timing couldn't be better with regard to the NASPER.

With as many states having implemented that have -- I don't think timing could be better, honestly. It sounds like we're on a good track; I think we just need to keep moving. Because those states who have not implemented yet, those who are

not in the process of, they are probably going to feel a lot of angst to do so. They are just going to not be the only ones out there who do not have prescription drug monitoring programs in place.

So it's going to get competitive again. While we're moving, I think we need to maintain a momentum.

JUDGE FADER: Now, before we begin with what Bruce and David want to tell us, I would like to ask them is there any questions by way of cross-examination of this. This is kind of the way we do it in court, is somebody puts on their case, they ask them questions about it, and then we listen to what the other side has to say. I think that that's appropriate here. Questions?

MR. KOZLOWSKI: Yes, if I can. Would you do some clarification? I went up to your website and I looked at NASPER funding and it specifically says, NASPER was to foster the establishment or enhancement of PDMPs that would meet consistent national criteria and have the capacity for interstate exchange of

information.

A stand-alone system does not meet either of those criteria for two reasons. There are no national standards, and secondly, David can talk to you about the technological challenges and costs creating a silo that would have any potential of interstate communication. Can you clarify that, please?

MS. JOHNSON-ROCHEE: I cannot, honestly, because that is not my area. I can plug you into someone who can at our policy office. I can give you that information before we leave here today.

MR. KOZLOWSKI: All right. Sounds good, Thank you.

JUDGE FADER: All right. Are there any other questions? Bruce, are there any other questions that you have?

MR. KOZLOWSKI: No. The only thing was that I would very much like to hear from the clinicians, since I'm not a clinician. Dr. Lyles has submitted to you a secondary statement in which he supports the HIE --

JUDGE FADER: Yeah, we're going to get to those statements when you put yours on.

MR. KOZLOWSKI: I appreciate that but I would like to hear from the clinicians. I think that would be invaluable.

JUDGE FADER: All right. Who else wants to go second with regards to questions of Ramsay? Just questions. Go ahead.

MS. DEVARIS: Given the state of poverty that we are experiencing, I am envisioning that the legislature is not going to do anything unless they can see some out, financially, to save them from putting money out.

It is possible to have any of these representatives of these funds come and testify that they are available?

MS. KATZ: The way that we would write the implementation grant for the Harold Rogers, for the $400,000, is we would have a specific bill number, or bill that has passed -- which isn't going to be the case -- but, you know, that House Bill 12345, and we

would refer to it in the grant application and we would say that we do not expect this to be funded, obviously, unless this becomes law.

MS. DEVARIS: Okay.

MS. KATZ: The bill would also say that it would not be implemented unless the Harold Rogers funds were granted. So it's very circular.

MS. DEVARIS: Okay. Because I could see that dead in the water before you got there.

DR. FARAH: Absolutely. No, because other states have done it exactly in that same format.

You have to start somewhere and the proposal is contingent. That's why the timeline, January, April, July. Your point is very well taken. It's been discussed in just about every meeting that we talk about.

The impression of stand-alone is that it is -- a silo is a little bit of a misrepresentation, because the way it works is the silo is actually just the same silo as all the other states have had these silos. You can go in and retrieve specific

information that goes back to the hub from which you get the information. That's what happened in Kentucky --

MS. KATZ: Only in Kentucky and Ohio have they worked that out.

DR. FARAH: That is correct.

MS. KATZ: They have worked it out to have a sharing system.

DR. FARAH: That's correct. So all we need to do is to set it up in such a way that we will be able to communicate with others and then it will not be as much of a problem.

JUDGE FADER: All right. Now, just a second now. Board of Nursing, any other questions? Any other questions for the Board of Nursing?

MS. DEVARIS: No.

JUDGE FADER: Okay. Who wants to ask Ramsay some questions next? Marcia.

DR. WOLF: One of the things that you stated towards the end was just not the silo effect, but when the new system is available with the new technology,

that the old information is magically going to be able to be transferred.

I have yet to see a system of a proprietary type of a setup where the information gets transferred and is usable and is flexible as the new data that gets put in there.

Is it impossible to create something like that were you can actually make that transition and make it work? I don't know of one that there is.

DR. FARAH: The answer to your question is how you capture the original data elements.

If you have so many fields of so many elements that where you enter into a database, it's completely different than if you are making notes on a page that you want to copy and send out.

So it all has to do with how the basic structure is implemented, that you can take field 1, 16, 74, and 92 to go here, field 23, 27, and 28 to go there, et cetera. So it's an IT technical phenomenon.

If we're going to do this as a silo, there

is absolutely no reason why we can't be talking to the people who today are envisioning setting up whatever Maryland is going to have. This should be a component of where we are going to be going with this.

Because I don't know exactly what is going to be done in Maryland, how it's going to be structured, who is going to be doing it. There is no reason whatsoever that we cannot coordinate our efforts to see how, eventually, they're going to have the data so that you can set this up to be able to translate it.

MS. KATZ: I'd like to comment on that.

JUDGE FADER: Wait, wait, wait. Marcia, do you have any other questions?

DR. WOLF: Yeah, I don't think that answered the question, to be honest with you. I just -- I don't care how you collect the data, if the system is obsolete before it is implemented --

JUDGE FADER: Well, David Sharp used a couple of letters with me with some type of system that I've

forgotten already. It began with a T, didn't it? The universal exchange thing, what do you call that?

MR. SHARP: It's interoperability.

JUDGE FADER: What is it?

MR. SHARP: The question here is interoperability.

JUDGE FADER: Yeah, well, wasn't there a standard thing?

MR. SHARP: No, I don't want to confuse the group. But no -- I could respond.

JUDGE FADER: No, let's get here. Marcia, anything else? Do you have any other questions?

DR. WOLF: No.

JUDGE FADER: Okay. Gail.

MS. KATZ: The only thing I was going to say is, I think the only thing we could truly do, quickly, as a stand-alone is -- would be to look at some of our neighboring states. Look at Pennsylvania, look at Virginia and say, we're going to do the same program so that we can at least exchange with them.

But I think if we wait -- if we want to

create a system that will, in fact, merge itself into the system that David is working on, I think we will not be putting this into effect for years. I'm guessing three.

JUDGE FADER: We're going to talk to him about that. You can cross-examine him when he gets up there to talk about this. Is there anything else? Okay, Nicole.

DR. MARTIN-DAVIS: Yes, and I had sent you an e-mail. My question was in terms of how to get -- after we get past the grant money, how do we pay for the stand-alone?

Like I had said before, you had mentioned having physicians -- like we pay for licenses and we pay for things like that. But when the state trooper, or whatever it was from Virginia came and spoke to us, the doctors in Virginia that have this at their beck and call for free are not using it.

Okay. Now, maybe it's too cumbersome, maybe they don't understand it, but at this point they have it for free and they are not using it.

I wouldn't pay for it, personally, and I can't imagine that somebody would legislate that I would have to pay for it, or have to be part of this entity in order to practice medicine like we do with CDS licenses and things like that.

DR. FARAH: Okay. Very good point. I got your e-mail. I guess you didn't get my response but it might be sitting in my Outlook.

We have to pay for it no matter what format it comes in, whether it's stand-alone, or whether it's part of the big picture. Do you think if you're part of the big picture there's no money that's going to need to be appropriated to serve this kind of a program?

No matter how you slice it, if you want a program like this you have to have some money, no matter where the money is coming from, whether it's stand-alone or whether it's --

So the money, we have to look for and justify it and give proof that we need to have this program in the first place because with a new

program, you still have to pay. The problem is that it's just going to be a part of a big piece. Here you're paying the big piece of its own, this specific thing.

Where do we get the money? We already have CDS, which we are paying right now.

MS. ZOLTANI: Excuse me. Talking about CDS, right now the money doesn't go to drug control. It goes into the general fund. So it would be coming from the state.

DR. FARAH: Right. But you already have a setup where there is already a licensure which we're paying.

DR. MARTIN-DAVIS: We could potentially use that money?

JUDGE FADER: We would ask the legislature if we could use that money.

DR. FARAH: Exactly. It's a fee which is being already paid for a service that now we're going to put into use. So that's already we're paying a licensure fee for something we're not using.

JUDGE FADER: Any other questions, Nicole? Are there any other questions from anybody else?

(No response.)

JUDGE FADER: Okay. Now, let me make this comment and open it up. It is highly unlikely, in my opinion, that the legislature is ever going to agree that any funds or fines or things of that sort would be put to the support of an individual program.

The reason for this is historical. It is always historically subject to abuse, where the people who are trying to promote their own program are fining Fader $6,000 instead of the $600 which he should have been fined.

So the legislature, to avoid the indicia of impropriety, has avoided all of that stuff except in the most unusual of all circumstances. Anybody want to comment on that? Questions? Anything?

(No response.)

JUDGE FADER: Okay. Next, Ramsay, like you, I feel that we are going to get that $400,000. I think that we probably have four to five to one chance of

getting it.

The big question is, how can we be assured that that's going to even be close to what it is going to take to run the program, when we attended the conference in Washington D.C., and were told there that the annual cost of the programs are anywhere between 300,000 and a million dollars a year? So let me ask you or anyone else about that.

DR. FARAH: If you have 23,000 CDS recipients, each one is now paying $65.00 for a licensure. How much money does that make a year?

DR. WOLF: But that's going into the general fund now, isn't it?

MS. ZOLTANI: Exactly.

DR. FARAH: I understand that. What we're saying, if you're going to have a program like this, it's going to have to pay for itself, somehow or other, no matter how you stretch it. It has to justify itself, either by a return on investment, by lowering healthcare costs or criminal activity, whatever it is, or some kind of a fee generated, or a combination.

MS. KATZ: In answer to your question, it's $1,380,000 that you would be saying to the legislature we want to take out of the general fund and use for this purpose.

I think that might be a slightly easier argument than saying, find $1,380,000 to pay for this, but I think that in this legislative environment, good luck with that.

DR. FARAH: There's a portion to cancel the CDS licensure, period, because it's unfair and it's duplicative.

MS. KATZ: Okay. I'm just telling you.

JUDGE FADER: The point I am trying to make is we cannot, as far as I know, with any degree of predictability, tell how much this program is going to cost a year or how much it is going to cost to implement. So how do we know how much is going to be covered by that $400,000? That's what I'm asking.

MS. KATZ: The $400,000 is really an implementation grant. It's not supposed to pay for the operation.

JUDGE FADER: Suppose it costs $600,000 to implement it? That's an unpredictable amount of money.

DR. WOLF: We also don't know how much it's going to save on the back end, too. Are the physicians that write for medical assistance, or get medical assistance prescriptions filled, do they know what the patient's already gotten? Is there anybody that knows that from the state?

So if you have people that are using state funds, whether because they are retired teachers or they're state employees or they're on medical assistance, how much will there be a decrease in duplicate prescriptions?

MS. KATZ: Right. I will tell you that one of the outcomes from one of the studies on the efficacy of PDMs, the best thing -- I told you about this at the last meeting -- there was a very, very good presentation that had no notes because it's going to be published.

In any case, I went to him afterwards and I said, so you're telling me it doesn't show that it

does anything at all about overdoses and mortality from overdoses? You can't say it's diminished, nothing -- you just can't say that it's worked or it hasn't worked? What do they do? He said, well, in New York state we identified $70 million of Medicaid fraud.

So that is something that it might do. Is that our purpose? No. That's not why we're sitting here talking about it, but it's sort of a outlier that $70 million pays for a lot of database.

JUDGE FADER: One of the things that we're not discussing today is No. 10, and the reason for that is because until Michael has some sort of an idea as to what we're voting for, he really cannot indicate how much funding.

One of the things that Michael is going to be called upon is to tell us the best fiscal note and everything as to how much it's going to cost to implement this program. And, Michael, the answer is?

MS. ZOLTANI: He's not here.

JUDGE FADER: He's not here? Well, I would

suggest to you that were he here, he would shrug his shoulders, okay, because we don't have any idea.

Let me make another observation. I respectfully suggest to you that we are going to be far down on the pecking order of the recipient of funds when the legislature gets any money.

Okay. I don't know for a fact that that's correct, but I don't think that we're going -- with all the other things that have been cut, I don't think that we are going to be very, very high up on the pecking order.

Any other questions to ask anyone with regard to Ramsay's presentation? Bruce? David? How many years are we going to wait for HIE?

MR. SHARP: Well, if I have the floor -- I'm not a lawyer so I may get some of the jargon wrong -- but if I have the floor let me just sort of take you through the little piece that I have mentally in my mind about some of the discussions that have been going on.

So rather than sort of doing a compare and

contrast to a stand-alone system, if it's the will of the legislature, if it is the will of this group to make a recommendation and identify a specific technology, then so be it.

It is important to note that the legislature had already made a decision to invest in a statewide health information exchange. They did this by passing House Bill 706 last session.

Under the prior administration, the Ehrlich administration had also made that same commitment. They just hadn't got it far enough along.

The O'Malley administration came in and said, we think this is a good thing to do and we're going to carry the charge forward.

The Maryland Health Commission is tasked with heading up health information technology for the State of Maryland. That said, we have $10 million already invested through the hospital rate-setting system, the all-payer system that's funding the early stages of development.

We have recently applied for two grants,

one up to $9 million dollars and the second one up to, I think it is $17 million, from the American Recovery and Reinvestment Act of 2009. We should be hearing about that funding between December --

JUDGE FADER: It's $9 million?

MR. SHARP: $9 million for one, and up to -- it's up to 9 for the first one and up to 17 for the second one.

JUDGE FADER: Okay.

MR. SHARP: But to some of the points that have been made, there are no absolutes with grants. It's a competitive process. We'll see what we get when we get it. What we do have on the table is the 10 million for the implementation, so it's going forward. The development began in August. It is being built on a service level basis, which means at first it will do medication history delivery, then it will move into transferring clinical content information.

JUDGE FADER: All right. Now, what was the first one?

MR. SHARP: Medication history.

JUDGE FADER: Well, isn't that what we're talking about?

MR. SHARP: In part what we're talking about.

JUDGE FADER: Let me ask you a question. I'm wondering if you're implementing that, would Harold Rogers approve any of the use of that funds for that project that you're doing first, medication, that's all. I don't know the answer to that question.

MR. SHARP: And nor do I. Honestly, I couldn't guess.

JUDGE FADER: Okay. Go ahead, David.

MR. SHARP: So the initiative is moving forward.

Any ideas for implementing the prescription drug monitoring program and using the statewide HIE? The core spending is already occurring so this is an add-on. So while we're doing medication results delivery initially, this would be an add-on to that.

Now, does that mean it would be in effect any sooner or later than if you compared it to the stand-alone system? No. You're looking at roughly

three years for this kind of service to be deployed and honestly say it is deployed. Now, we can sort of say if we get credit for a partial deployment, we can probably have that up in roughly a year into 18 months.

JUDGE FADER: What do you mean by partial deployment?

MR. SHARP: I mean, instead of connecting all the pharmacists to the system, you had a core set. Maybe you chose Baltimore City, because there's some speculation that this may be a high abuse area, or you chose Montgomery County. So there is some ways to do this is you want to sort of do a gradual implementation of that sort of service. But more to the technology and some of the other pieces --

DR. FARAH: May I ask a question while we are at that, before we get to the technology?

JUDGE FADER: How much longer do you have?

MR. SHARP: I can go as long or short as you want. It's your show.

JUDGE FADER: That's what we're afraid of.

All right. No, but I mean how much longer on your presentation.

MR. SHARP: If you want to give me three more, five more minutes.

JUDGE FADER: Then I'll give you three to five more minutes, then we'll ask questions. Go ahead.

MR. SHARP: Okay. So what you are looking at from the statewide HIE is sustainability. It is where all the states are moving to with technology. It is sort of the wave of the future.

JUDGE FADER: It's Barack Obama's prerogative also. And Bush's.

MR. SHARP: It is his passion. And part of this is because of your consistency in standards, you get away from the disparate technology. Because systems have name and demographic data, it doesn't mean you can move that data because it's the source code that drives the information. It takes us out of being locked into vendors, so if pharmacies or hospitals or anyone wants to change vendors, they're able to do that on the fly and not feel that you can't, or you have to

do so at a significant price.

One of the huge aspects beyond the technology are the polices related to privacy and security. They are paramount because no matter where you store the data, if you don't have robust policies around safeguarding it, you have what you had in Virginia. If you don't have protections around it, you'll find that people are doing more transactions using other people's names to protect their information from getting into this sort of system.

You have realtime access. Realtime can be defined as almost by the minute once the information flows into the exchange. You have consistent controls and you have ease of integration to electronic health records where physicians and hospitals are already implementing this technology.

So this kind of data can be pushed through the system without the physician needing to go request it, to take a look at it and see what's going on. Now, I could go on and on and on, but I'll stop there.

MR. KOZLOWSKI: The only thing to add to that is, we also have support in the context that CRISP, which is the non-profit that was formulated to work and to make this a reality, initially in Maryland, Erickson Retirement Communities, Erickson Health Information Exchange, Johns Hopkins Medicine, MedStar, and the University of Maryland Medical System --

JUDGE FADER: Erickson's fallen on some bad times, my man.

MR. KOZLOWSKI: They have, but that is -- I can tell you about some of that afterwards. It will move forward just as it does today and be transparent. There already is the transfer taking place.

JUDGE FADER: Well, there's certainly not going to be any 7 filing for Erickson, as opposed to an 11.

MR. KOZLOWSKI: Right.

JUDGE FADER: Anything else you want to say, Bruce?

MR. KOZLOWSKI: No, sir.

JUDGE FADER: Ramsay, do you have any

questions?

DR. FARAH: Yeah, I would like to get clarification. There are some very interesting points that I would like to understand. You said that if we think it's a component of the medicine piece as the initial phase of this large system, you said it can be up and running in about a year or so. Am I understanding that correctly?

MR. SHARP: The medication delivery, as the service was designed.

DR. FARAH: Yes.

MR. SHARP: So think of it as the Surescripts piece that goes to all payers. Whereas Surescripts -- most of you know that or have heard that name -- doesn't go to all payers. It only goes to payers who are willing to pay for that information. Whereas the medication delivery would reach to everyone for all payers, including what Surescripts does not get as cash transactions, this system would not --

DR. FARAH: So at least whatever you are setting up is pretty much in the realm and domain of

what you are doing. And you said it takes about a year to get that going, right?

MR. SHARP: Just for the medication history, but not for the prescription drug monitoring program.

JUDGE FADER: When you say just for the medication, are you saying just for Baltimore or Montgomery or just a specific subdivision?

MR. SHARP: If you wanted to do, say, a pilot and you wanted to -- instead of saying all of the state had a prescription drug monitoring program through the exchange, you could pick a section, and that would take about a year, give or take. But to deploy it for the state, you're talking at least three years. The entire state.

DR. FARAH: All right. If we want to do the entire state on prescription drug monitoring and piggyback on what you're saying is the initial phase of whatever you are doing, what is the reason it takes a year or two or three? What are the parts that require that? Is it staffing, is it boxes? What causes the one year, the two years, the three years?

MR. SHARP: It's a combination of architecture and combination of policy. Because, what happens is, it's not buying the computers because the pharmacy information systems exist today.

It's making sure that each one of these systems that are different -- because you mentioned McKesson, there's so many out there -- to make sure that you do the harmonization of that architecture.

One of the statements you mentioned was demographics. Demographics, if that's the core piece, resides in all the computers. But because the source code is very different, it's not like I can reach into this one and pull David Sharp out and push it over here. The mapping is entirely different.

So you have to do that harmonization on the technology standpoint, and then you have to deploy the policies because no one has really defined what user access should look like, what authentication should look like, what authorization should look like. So it needs that time to develop those policies in order to --

JUDGE FADER: Marcia, you're second. We have to wait for Ramsay to finish.

DR. FARAH: So it's manpower, not a hardware issue?

MR. SHARP: Well, it's not hardware issue and I would hesitate to just say manpower. I would call it more of the implementation of both policy and the technology. You've got to harmonize the technology. You have to test it. And then you have to develop the policy that controls how the data flows. Otherwise, the system becomes open-ended and anyone would have access to it and that's not what you want. At least I've heard that.

JUDGE FADER: All right. Ramsay, do you have any further questions to ask David?

DR. FARAH: The second question is, do you have the funds appropriated for that piece, or we don't yet out of that $10 million?

MR. SHARP: We have $10 million appropriated for the early implementation, and one of the use cases -- services are considered use cases -- but the

services, we have 23 services that have been approved for funding. Of those other services, the first one is medication history delivery. But medication history delivery is a cousin to a prescription drug monitoring program. You can't say, well, if I deploy medication history delivery, therefore we now have a prescription drug monitoring program. You do not.

What you have is some parallels that you can pull from because you've already deployed some of that same surface level technology and policy. So you have some of that, early components.

JUDGE FADER: Ramsay, anything else?

DR. FARAH: No.

JUDGE FADER: Marcia?

DR. WOLF: So the medication history piece is really -- are you already collecting that data? You're going to be implementing collecting that data soon. And I understand that that's going to be then the basis for setting up a PDM which will then require parameters and how you deliver it to us. But you're saying that the data collection is already taking place or will be?

MR. SHARP: No. The data collection will be taking place. What we're doing now, because this started in August. The legislation passed in the spring.

As Bruce mentioned, we wanted to go out and find this multi-stakeholder group that could develop it. We gave them the state health IT plan and said, here's our road map. We now want you to work with us to implement.

So we are now getting the technology in place and we have established a policy board, which actually meets for the first time next week. So you need the technology to grow, and the policy people to sit down and define the key components to make this happen.

DR. WOLF: When do you anticipate actually collecting pharmacy history data?

MR. SHARP: That is still within -- we will have some hospitals, and I'll just pick on hospitals because that's the first place in our plan that we went

to, early next year. When I say early, probably end of first quarter some hospitals connecting and exchanging that data.

DR. WOLF: And which hospital? Are they inpatient, outpatient?

MR. SHARP: It would be outpatient.

JUDGE FADER: That's what your report said, it would be outpatient.

DR. WOLF: Right. And then how long does it take, or do you anticipate it will take from getting the hospital outpatient to the large chains, et cetera?

MR. SHARP: I would say, if all goes as planned, within a full 12 to 18 months we should have the medication history of that entire component deployed to hospitals that are willing to use it. Because a hospital is not forced to use it. A hospital or a physician's office could go, no, I'm not using this. I don't want to use it.

MR. KOZLOWSKI: But it will be there.

MR. SHARP: It'll be available.

JUDGE FADER: Gail, wait a minute. Marcia.

DR. WOLF: No, that's good. So they are actually going to be collecting data even though it may not be usable right away.

MR. SHARP: Can I clarify a point, just to make sure I don't misstate or misinterpret what you are saying. There's a difference between collecting it and us holding it in here.

DR. WOLF: Yeah, I don't mean that. Availability to get access to it.

MR. SHARP: Okay. Because we're building the spider web into the different technology to be able to have access to it on demand.

DR. WOLF: Will you have access to retrospective data then?

MR. SHARP: If it's available electronically and it's in the host system. Some host systems may have some. Some may have little. Some may have none. Because it's really subject to where we --

DR. WOLF: But does that then put at the mercy of these different systems purging any of their data?

MR. SHARP: No, it does not. Because what happens is once you -- the data is pushed to what's called -- we may be getting too technical but I'll just say it goes to edge servers. Once the data gets to the edge server, they can't purge it. It's stuck.

MS. KATZ: I can purge off their system but not yours, right?

MR. SHARP: Yes.

JUDGE FADER: Just a second. Do you have anything else, Marcia?

DR. WOLF: No, thank you.

JUDGE FADER: All right. LaRai.

MS. EVERETT: I just have a question. If you're in the first step of gathering the medication and setting up whatever you said, the system, I guess the infrastructure for it, and you were to have a pilot program, let's say Baltimore City as the Judge was saying earlier, implementing at the same time, wouldn't it have been easier, because you're all making the same kind of system, to then further expand across the state?

MR. SHARP: Yes, it's a terrific question and great point. No doubt. But, at this stage we don't have that authority because no one has said, you shall do this.

So we've never taken into consideration -- until six months or a year ago it never occurred to us that prescription drug monitoring may be a viable component to map into the plan. But if the legislature came back and said, you know, we are now requiring and you have to do it, the timing of it would be fine. So, yes, indeed that is a good point.

JUDGE FADER: LaRai, anything else?

MS. EVERETT: No.

JUDGE FADER: Gail.

MS. KATZ: I just wanted to clarify. Let's say we decided to go just with the Baltimore City pilot, but some of the institutions in Baltimore City, Kaiser, for instance or -- I don't know --

DR. WOLF: Hopkins.

MS. KATZ: Well, Hopkins is part of this program. I don't know, St. Agnes Hospital said, no.

We aren't going to participate in this. I mean, you have no authority to --

MR. SHARP: We have no authority.

MS. KATZ: So we would have a very incomplete -- no matter what you do, you would end up with an incomplete picture as things stand now.

MR. SHARP: Well, it depends. The answer to your question is really sort of two-fold. One is if the entity, the endpoint chooses to connect to the exchange, then the information is there. Because, remember, they're not keying any -- there's no separate keying. It's already there.

Today that exists with all technology. That same notion exists with patients who show up for care at the provider's office who may choose not to tell you something.

The only way you will ever get 100 percent -- forget what technology you use -- is unless you mandate that the endpoints use it. Whether you use a McKesson system or a stand-alone system or an exchange, there is no way you're going

to enforce that.

What this does is it creates the highway and puts it there. So if people choose to use it, this offers a seamless way of using it. It doesn't require you to do anything additional. It doesn't require manual entry. It doesn't even require the pharmacist to go, oh, shoot, did I remember to do this? Because by virtue of filling the prescription, the data is already collected. It doesn't matter if I have a PDM or if I'm a cash transaction, it captures that information. And that's really one of the value adds of something like this.

MR. KOZLOWSKI: Business relationships will force them to participate.

MR. SHARP: Yeah. And one of the other things to keep in mind is this keeps this vendor neutral. So if you're a small EPIC store and you want to buy a product, or you can't afford a top end system, you can do that. If you are a physician and you use a EHR that you like, it doesn't require you to use a select EHR. You can any electronic health record

system you have.

DR. WOLF: Suppose you don't use an electronic health record?

MR. SHARP: Any?

DR. WOLF: No, none. Suppose the option is none.

MR. SHARP: If somebody chooses to not use technology, then if you don't have a computer, you don't have a computer.

JUDGE FADER: Well, just a second. Gail, anything else?

MS. KATZ: No, I think I understand.

JUDGE FADER: Okay. Al, go ahead.

MR. FRIEDMAN: I have a question about practical logistics. The bill is introduced next session. It passes. We have an effective date. The state system is three to four years, maybe, until it is completely developed, although there may be a component ready earlier, the medication profile.

MR. SHARP: Well, in many. Because, remember, there's 23 that we're doing. So we're saying

between now and the next three years-ish, it will take us that long to do 23 different types of services.

MR. FRIEDMAN: Right. So if the group chooses to advise that data capture be part of the state system, how does the bill address, or the effective date of the bill address --

In other words, we can't implement the bill until the state system is ready and that everybody's on board. Because the mandate is, all prescribers who dispense and all pharmacies that dispense have to be able to feed into the system. So the system has to be able to incorporate that on day one.

How do we insure that happens if that's our recommendation or we have an incomplete picture if we do a pilot?

MR. SHARP: Well, let me explain a little bit more about how the services are phased in. So let's say the first one is the medication history delivery, which it is, and over the next eight months, ten months, it gets implemented. That means for that particular service, anyone can have access to the

information. Any of the data, the pipeline of the road is now there. You can pull information from it.

But what it doesn't say is when the other services will be up and running. So don't think of the medication history delivery going, well, shoot, it's going to be that particular service is three years out. It's incremental. And I go back to saying there's really no way you can sort of guarantee compliance on the endpoints. It's really the will of the organization.

But if you put in place the system that's about as "effortless" as you can get, then there's less push back from the providers and the physicians about using it to query the patient information, and the pharmacists about loading information.

If you make it invisible to them, that they can hold onto their current workflows and do what they do, treat patients, fill prescriptions, advise and counsel patients, and what happens in the middle is automatic, then the beauty of it is people will use it. But if you take the pharmacist, or the

physician, and you layer in an additional workflow or costs, there's reluctancy. I think someone here said, I'm not going to buy that. But if it's built in as part of the system, she's likely to use it.

MR. FRIEDMAN: But wouldn't it be incumbent upon us, either through the legislation, the statute itself, or through regulation, to indicate how people need to submit the data? Isn't that going to have to be a recommendation somewhere along the line, what the accepted methods of transmission are going to be?

MR. SHARP: No, because it's one of those if you choose to use the system, it's there. If you choose not to use the system, it's not there.

It doesn't say that pharmacists have to hit this button every time they fill a prescription that's, say, a controlled substance. If you're filling a prescription, that information is there.

If you're a physician and you go to your EHR to look up a patient -- I'll just give that as an example -- you're able to access the data. It populates it automatically. It says, here's a list

of prescriptions that have been filled at CVS, Rite Aid, Walgreens, EPIC.

MR. FRIEDMAN: That's assuming that each organization or each pharmacy provides data to the system?

MR. SHARP: Well, today you don't have a choice, because when you fill prescriptions it checks the eligibility with the PDM instantly. So it's providing data to the system just like that. So you're not going to do an additional step. The information is going to be there automatically, particularly if you want the drug paid for through a carrier. That data is flowing. And the cash transactions will get loaded into the system anyway, and it will pick that up as well.

JUDGE FADER: All right. Just a second. Anything else you have to ask him?

MR. FRIEDMAN: No.

JUDGE FADER: Okay. Linda.

MS. BETHMAN: Two questions. If a PDM program, not your medication history data collection,

but a PDM program with all the policies contained therein that we've been discussing, were to be an adjunct to your project, what do you think the timeline would be for that?

MR. SHARP: As in terms of developing the policies that support the prescription drug program?

MS. BETHMAN: Uh-huh.

MR. SHARP: Well, the question is about the timeline. It's interesting, because there's a policy board that's an independent policy board from the state, that oversees the policy, all the policies of the statewide HIE. It was designed that way to set up to be independent so it doesn't have influence.

That group is going to be dealing with the issues of policy anyway. So if you have another advisory board that's either a subcomponent of it, or the legislature chose to have the policy board take care of these issues anyway, then that would actually be more ideal.

But today this group is going to be addressing the same issues. Because, by way of

example, access authentication, authentication, audit, these big policies that affect the prescription drug monitoring program affect everybody who has access to the system. So this group would be developing it one time anyway and they are starting next week.

So if you said, when will they finish them? Probably a full twelve months to really have the core set. It may take, if there is a prescription drug monitoring program that's layered on to the HIE, it may take some specificity that requires another half year or a year to really conceptualize them and then test them. Because once you put them to theory, we like to take and sort of data test them to make sure that they apply and appropriately work. So, you're probably looking at a good year, year and a half on the policy side.

JUDGE FADER: Linda, any other questions to ask him?

MS. BETHMAN: Yes, one more question.

JUDGE FADER: Go ahead.

MS. BETHMAN: If a PDM, with the policy support by this advisory board, were to be hooked on to your program, would your money, your grant money, be able to cover that?

MR. SHARP: I'll answer it this way. Today the $10 million is specifically to do roughly 23 specific services. But the prescription drug monitoring program, while if it were a 24th service, it still plays on nearly the majority of the components that were implemented that were already put in place to support the other services. So you would be adding some uniquenesses, but you wouldn't be starting from scratch, because already that infrastructure would be in place.

MS. BETHMAN: So I guess my question is, the Judge already asked, do you think Harold Rogers would be applicable to your program? Would your program grants be applicable to the PDM?

MR. SHARP: No, they would not. And the reason why is because you had to start out the gate that way, and we didn't have the knowledge to start out

of the gate that way.

MS. BETHMAN: And you've already put in the grant request for the other two?

MR. SHARP: They are in the decision making process.

MS. BETHMAN: Okay. All right.

MR. SHARP: So, yeah, there would be more cost to implement it. But to scope out that cost architecturally is a significant task. Until we are told that you have to spend the next three months really developing the architecture, scoping it out and pricing it, you wouldn't want to set a team of programmers to that process. That's one of the reasons why today if you said, is it $400,000 or a million dollars, in all honesty no one would know that answer.

JUDGE FADER: Just a second. Linda, anything else?

MS. BETHMAN: No, thank you.

JUDGE FADER: Okay. Marcia, we're back to you.

DR. WOLF: You've indicated that there are 23

mandates, or 23 objectives, that the system has. This would be a 24th. I think I also heard that you said that this could be made a priority.

What are the competing elements to that, and is the priority based on funding ability, or is it that if we implement this it becomes priority number one? What are the competing influences, and what are the competing issues with regard to making this a priority?

MR. SHARP: We spent almost three years pulling various multistate core groups together who eventually published seven pretty significant policy reports.

These teams of people, essentially, chose the hierarchy and the services they felt from the physician, the provider, the consumer, that made the most sense to them. So if this were to be interjected as a priority, then so be it. It wouldn't cause chaos to the implementation process.

What we tried to do in the state, in development of the IT plan, was honor the hard work

that these multistate workgroups did over the last several years. So there really isn't any significant disruption at all. If the legislature said, you need to implement, it needs to be in by blank, then so be it.

JUDGE FADER: Marcia, anything else?

DR. WOLF: Yeah, I have one more question. You indicated the seamlessness and the ability, but what about the providers, the actual physicians on the receiving end that do not use an electronic medical record or electronic health record? Would they be able to access and implement through the web through some service?

MR. SHARP: Well, that's a good question. You don't have to have an electronic health record, you just have to have access to the Internet.

But with all the incentives that are being put in place from the federal government, and even the state, for physicians to adopt electronic health records, if a physician can get $44,000 up to, under the Medicare and Medicaid side, and then the state is

going to parallel that through the private payer's component, I would be surprised at the physician that sort of scoffed at that.

DR. WOLF: You've got a lot of us that are out there that are independent. The other thing is that we're starting to see some published data that shows that the electronic health records really don't fix anything and don't help anything. There were a couple that was published, I think it was out of Yale recently, that it's just not --

JUDGE FADER: Let me just state, because Linda has to leave so I've got to inject a little make believe into this.

We're going into April of next year. The legislature has decided that until this problem of what database we are going to use is taken care of, they are not going to go forward.

So they pass a bill, they appropriate $100,000, for a seven-or-nine person committee, to determine which one of these systems will be used, the expense of the system, and the time to implement

it.

The committee comes back and it says, we looked at all these systems around the country. We feel that the Oklahoma system is completely consistent with the culture of how the State of Maryland approaches this. Therefore, it will cost such and such amount of money. This is it. This is what we should use.

And by the way, David Sharp and Bruce Kozlowski, you have to find a way to implement this system and to trigger it in to interface with the system that you are implementing now. What about that, can you do that?

MR. SHARP: I would say, one, that insures me I have job security until I retire. Two, I'll take $3 to $5 million to do that. Because when you look at harmonizing technology and building interfaces, there's a whole industry that's built around that. Your IBMs, Northrup Grummans, this is their bailiwick, but look how big they are. Your CSCs. You can do this, but it is a cash cow and it is a journey that will take many

years.

JUDGE FADER: Well, then, perhaps they come back and say, and by the way, if you can't do it, the police, the disciplinary boards, and more importantly the physicians who need this information to treat patients, have assured us that we need to go through a stand-alone system. They may say that, too.

Linda, I just wanted to take you down the future lane and see what that could do, because it seems to me that there has to be some type of possibility that the legislature is going to understand that this cash cow, this money aspect of what we're discussing now, until that's resolved, okay, nothing else. Okay? Can you write us a check for $100,000 today?

MR. SHARP: Technologists will tell you, rip and replace technology is the worst form to invest in. And what you've described is just that.

JUDGE FADER: I can understand this, but sooner or later, and I'm going to resume the discussion, we all have to come to the awareness that

this issue somehow has to be studied further to determine what system, how much time for implementation, how much it's going to cost, et cetera, whether we rent the system from Oklahoma, we go to McKesson, we wait for your system, or do that. And that's what I wanted to make. Marcia, you had any other questions?

DR. WOLF: No, thank you.

JUDGE FADER: All right. Ramsay?

DR. FARAH: No, I'm not going to ask any more because I think what you just told me, that if this passes and the legislature says this is a priority, you're telling me it's going to cost $3 million dollars.

However, what we are asking here is going to be part and parcel of everything else you are going to be doing sooner or later anyway. So this here has the elements you're going to need. So just because we pass it as a priority does not mean that we have to carry the whole brunt of the cost of doing this.

MR. SHARP: Correct.

DR. FARAH: So how much you would have had to pay to get those 23 programs up and running, 90 percent of what we need here has already been taken care of by the 23 programs.

MR. SHARP: Correct.

DR. FARAH: And so you are just putting one program ahead, with having all the elements that you're going to need anyway. It will be mandated rather than capriciously, I want to play ball or I don't want to play ball, and so I don't see any reason why we cannot -- if we're going to use that system -- put it to the legislators, if they will, to view this as a priority, use the Harold Rogers money for an implementation program, and be the first thing that you are going to be doing here. Because whatever we do here, you're still going to need it for everything else you are doing.

MR. SHARP: Correct.

DR. FARAH: So you're not putting them on the back burner, you're enhancing what they're going to

need eventually anyway, except that you're moving the time table for this program to be number one.

JUDGE FADER: Ramsay, anything else? All right. How about the police on this? How fast do you need this system? How important is this going to be to you with regard to anything that you're dealing with? You've got three to five years. You've got two years. Could it really make any difference to you?

MR. MOONEY: No, because we've been without it.

JUDGE FADER: How about the disciplinary boards? Linda? Donald? What about that?

MR. TAYLOR: Really makes no difference to us.

JUDGE FADER: Okay. How about the pain physicians? Ramsay? Marcia? Devang? Anything?

DR. FARAH: Well, the problem is addiction, very honestly. Diversion is the biggest problem. These are the people who are suffering most today. This is the biggest problem.

JUDGE FADER: All right.

MS. KATZ: But will this identify those for you?

MS. EVERETT: No.

DR. FARAH: Yes. I don't agree with you.

MS. KATZ: I understand, but there is nothing that supports your position from a scientific standpoint. The studies that have been done don't show that it is effective.

DR. FARAH: I don't know what you're talking about.

DR. WOLF: That there's enough access to the drugs from an illegitimate source that they will go to an illegitimate rather than a legitimate source.

DR. FARAH: No. The studies have shown that prescription drugs is the number one cause of addiction and diversion.

DR. WOLF: Right. But if you close one door you open a different door.

MS. KATZ: All I'm saying is the PDM doesn't address --

DR. WOLF: No, they don't.

JUDGE FADER: All right. Now, any other discussion before I call for the vote for three distinct possibilities.

Number 1, we wait for the Health Information Exchange to come on board,

Number 2, we go through a stand-alone system,

Number 3, we talk about renting some sort of software to look into the possibility from some other state acclimated to ourselves.

DR. FARAH: I think 2 and 3 are the same because most often with a stand-alone system you may very well need to rent or borrow a contract.

JUDGE FADER: Any objection to anybody combining 2 and 3?

(No response.)

DR. FARAH: All right. I'm getting ready to then say, how many people feel that we should -- it is going be interesting here, David, because you have Bob Lyles' vote and you have Bruce's vote, so you've got to raise two hands.

MR. SHARP: And a foot.

JUDGE FADER: Okay. How many people think that we really need to wait for the Health Information Exchange? All right. One, two -- LaRai?

MS. EVERETT: I can't decide.

JUDGE FADER: Okay. One, two, three, four, five, six, seven, eight, nine, ten, eleven, twelve.

How many people think we should go to the stand-alone system?

MR. SHARP: I should have had three.

JUDGE FADER: Okay. Now we have thirteen. Okay. How many people go for the stand-alone system? One, two. Okay.

MS. EVERETT: Well, my only dilemma -- I think the first one is the way to go, but I'm afraid we will lose our funds by waiting. That's my only -- that's why I'm like --

MS. KATZ: You wouldn't lose the funds.

DR. WOLF: The implementation funds are what we're talking about. Yeah.

MS. KUHN: We can still get the grant, right?

DR. WOLF: Right. Yeah.

JUDGE FADER: Okay. No. 4, Information Submitted.

DR. WOLF: So, at this point, are we talking about data that needs to be submitted or are we talking about data that needs to be retrieved?

JUDGE FADER: No, we're talking about data that need to be submitted to the system.

DR. WOLF: But it's going to capture everything.

MS. KATZ: David was saying we don't have to submit it.

JUDGE FADER: I'm not so sure that the legislature is going to go David's way.

MS. BETHMAN: The PDM will still need the policy as to what information is --

JUDGE FADER: Yeah, but the advisory committee would determine that.

MS. KATZ: Sure. But I can see writing the implementation grant to direct the $400,000 toward the process of interacting with the HIE, and asking the

legislature to set the PDM as priority 24, with a great priority. You know, moving into the queue at the top, so that it happens in conjunction with what you're already doing with pharmacy records.

DR. FARAH: I take this a little bit further because, honestly, if we do not have this as the prime recommendation, Recommendation No. 0, before it gets to No. 1, unless this gets a priority, all of what you're doing here is going down the drain. It's going to be for naught.

JUDGE FADER: But this recommendation is that we let the advisory committee submit the information.

DR. FARAH: No, I'm just piggy-backing on what you said.

JUDGE FADER: Okay.

DR. FARAH: If we are looking for a grant to get some implementation money and we're going to wait until they are up and running, if we don't have a recommendation to the legislation -- that if what we just voted on just before, that we're going to use the new health information system for all the good reasons

that we heard, but this issue does not pick up priority, then all of what you're doing here --

JUDGE FADER: What issue?

DR. WOLF: It needs to be a priority.

DR. FARAH: It needs to be a priority that the legislation charges the new health information system for this to take place.

JUDGE FADER: For what, No. 4?

DR. FARAH: No, for the whole entire project. Because if it doesn't, we're dead in the water. All the time we have spent is going to be for naught, because four years from now it's not going to fly. You're not going to get the money if something is not going to happen for four years.

MR. GANDHI: It will just be one piece of the HIE and all of the discussion we've had and all the policies we are trying to formulate will be --

DR. WOLF: No. It needs to be the number one priority.

MS. KATZ: From the standpoint of the Rogers grant, I think it's going to give us some uniqueness.

MS. BETHMAN: I think so.

MS. KATZ: I have been to a lot of meetings, ladies and gentlemen, on your behalf. I must tell you that nobody has talked about becoming part of a universal system, that is statewide, that is funded by the state, blessed by the state.

Everybody is a stand-alone and has all the intended problems of being stand-alone. This is, I think, forward thinking in terms of saying, we want to be part of an electronic medical record system -- and I'm using that term completely wrong -- but as part of an HIE for the State of Maryland, that could in fact become a model for other states.

DR. WOLF: It's not just Harold Rogers. It's all the others that maybe think --

MS. BETHMAN: NASPER is focused on interoperability.

DR. FARAH: And that's great if they are charged with this being a priority. Because if it does not become a priority, talking about it from the Harold Rogers -- they're not going to give you money which is

going to mean something five years from now.

MR. KOZLOWSKI: Thank you very much.

MS. KATZ: Well, I think that if we would make the argument that using the $400,000 would accelerate the process, and that the state is making this the priority along with -- what is the term that you were using, you're developing now?

MR. SHARP: Medication history delivery.

DR. FARAH: That's going to have to be ahead of medication history delivery.

MR. SHARP: It's all timing.

DR. FARAH: I'm sorry, because the other one is elective. This is not elective. Every pharmacy should --

DR. WOLF: Right, right. Judge, in reference to No. 4. Recommendation No. 4.

JUDGE FADER: Let me back up. We all are in agreement that we recommend to the legislature that even though we're going to say, wait for HIE, that the legislature creates this position, that one of the things of first priority is to have them make an

application for Harold Rogers, to try to get a 24th aspect of the Maryland system going as quickly as possible with this? Does everybody agree with that?

DR. FARAH: And give it a priority.

JUDGE FADER: And give it a priority.

DR. FARAH: Because 24 has a feeling that there are 23 ahead.

MS. KATZ: Well, if 24's criteria but it has the priority all the updating done in conjunction with --

JUDGE FADER: Marcia, No. 4.

DR. WOLF: The piece of information that's not listed in here is who actually is picking up the prescription and should they be identified. I don't know that your HIE is going to capture that either.

JUDGE FADER: To my way of thinking, that is none of the business of this organization.

DR. WOLF: But if it's a fraudulent prescription there.

JUDGE FADER: Okay. Just a second. I've been teaching pharmacy law at the School of Pharmacy

since 1974. We go over this in great detail.

The COMAR regulations of the Board of Pharmacy indicate specifically that it is the individual responsibility of the pharmacists to assure that that prescription presented is a valid prescription intended for the patient. All right?

Thus, we talk to our pharmacist as to how they go about doing that. We instruct them to make notes in computers. If they do not know the patient, such as you're going to have a caregiver, then that pharmacist must call that physician and say, you're the physician who's in attendance. They have a caregiver. Is this person capable of making their own decisions or should I take the word of the caregiver?

Okay. Or the person comes in with a specific written authorization and says that it is supposed to go to the caregiver, or there's a guardian, or it's through nursing homes or assisted living.

But, to my way of thinking, this is the

primary responsibility of the pharmacist as a dispenser in here, and we go over that ad nauseam with them, Don, to cover their own backside, because they are the ones who are responsible for that.

DR. WOLF: But, in reality, somebody comes up to the window and says, I'm here to pick up the prescription for Mrs. Smith. The clerk goes and looks it up and pulls out the -- Mrs. Jane Smith? Yeah, Mrs. Jane Smith, that's the one. Here, sign here. Here's the prescription. Okay.

MS. KATZ: Have you ever gotten that kind of a call?

DR. WOLF: I have, rarely. But the issue is --

JUDGE FADER: We have not had many problems with that whatsoever because --

DR. WOLF: We have. Because people will sit in other physicians' waiting rooms and listen in and then go pick up, you know, Joe Schmo is sitting here. Finds out Mrs. Smith comes to the pain doctor once a month, and goes and picks up Mrs. Smith's medication.

JUDGE FADER: Well, again, we, as pharmacists, do not have any real recorded thing that's anything other than a suggestion that this may happen. We just have not had a problem, Don, as far as I know.

MR. TAYLOR: There are problems, but they are few. And we just don't usually take the name. There has to be some other piece of identification, such as birthdate or address or something. So we're not just giving out Jane Smith's. They have to identify who, where, or whatever.

DR. MARTIN-DAVIS: What if Jane Smith's grandson comes to pick up the prescription and he says, here's my valid license but his name is Thomas Johnson and you have no idea that he's really James Smith's grandson?

JUDGE FADER: We teach our pharmacists that this cannot come from the person who is presenting, saying I have a right to take the prescription.

We teach our pharmacists that this must come from the person whose prescription it is authorizing someone else to pick it up. If they do

not know that patient, and do not know that someone comes in regularly to get that patient's prescription, they should not fill that prescription, unless and until they are sure of that.

DR. WOLF: But they don't know who is going to pick it up when they fill it. They don't know who is coming to pick up this prescription when the pharmacist fills the prescription.

JUDGE FADER: I understand that, but you have practical in life for something that comes up with so few instances of problems, to the effect that someone actually knew that that prescription was there and that person picked it up.

I mean, to me, respectfully, you're going into an area that has caused so few problems over the years because the pharmacists are careful about this.

DR. WOLF: I mean, is there information out there?

MR. MOONEY: Not that I've heard, no.

JUDGE FADER: I'm mean, I can't tell you -- and I talk to the pharmacists every year. And I say,

this is your license on the line. This is the COMAR regulation that governs you. This is your responsibility. Don't expect anyone to help you out, except you. And I tried to scare them to death every single year, and so does Frank Palumbo. And I think that it works. Okay.

So, respectfully, I think you're asking to implement some words for a problem where none is really that material a risk. If it comes up, let us know. Donald will take care of it with another regulation. Anything else with regard to No. 4?

(No response.)

JUDGE FADER: No. 6, Access to the Base. Okay. Now, let me go over with you with regard to physicians and pharmacists. This recommendation, and all of the systems said that the physician and the pharmacist have to fill out a request to have access to the base. They are then given an access code number, and every time they enter the base, they must put that code number in, and that signifies -- because they have to sign on the application that it is for a legitimate

medical purpose inquiry, period. Anybody have any questions, any comments with regard to that?

MS. KATZ: Did we set any kind of training requirements for physicians and pharmacists before they can get their sign-on?

JUDGE FADER: No.

DR. FARAH: My concern is that I want to make sure that the legislation is such that they can only have access to their own patients.

JUDGE FADER: It says they have to have a legitimate medical purpose with regard to a physician/patient relationship. Yes, Nicole.

DR. MARTIN-DAVIS: So what happens when the new patient comes that I have no relationship with?

JUDGE FADER: It says in the thing here, and you'll see the material with regard to what's been added here -- their patient or prospectively a new patient. One or the other. It all covers the same thing. Yes.

MR. GANDHI: If this is part of the HIE, this will have a separate log-in?

JUDGE FADER: Everybody requires that you would not be logged onto the system unless they assigned you a number and you logged in with your number.

In other words, it says, in connection with the medical care of a patient in connection with the dispensing of a monitored prescription drug.

MS. KATZ: Could you assign it to someone in your office? Let's say you developed a protocol for all patients with certain diagnoses.

JUDGE FADER: No, you're not supposed to assign it. You're supposed to access it yourself.

DR. FARAH: If you do that, then the responsibility is still on you.

JUDGE FADER: The physicians and the pharmacists have to sign indicating that they will only access themselves. They cannot designate it to anyone. Donald.

MR. TAYLOR: I guess my concern is if we are using David's system, everything is online.

MR. GANDHI: That is my concern too.

MR. TAYLOR: It requires no extra step on the pharmacist's part. Now, you're saying he has to have a separate log-in number to check a patient that's standing there at the counter. Now, you're throwing a roadblock in the pharmacist's flow, his work flow. If everything is there, why require a separate log-in?

JUDGE FADER: Because there's just too many people that are going to be accessing information on the neighbor across the street, the woman they're intending to date next week.

MR. TAYLOR: Well, I think you ought to certify that it's your patient. I agree with certifying.

JUDGE FADER: But you have to know who it is that's entering the system. Let me just say this to you, Donald. You're a pharmacist. I'm a lawyer. I don't trust anybody, okay, and neither do the systems and the people who have implemented this.

There is no system alive that allows anybody to implement this unless they put an access code in to identify themselves. And when they sign

that application for access, it says that I understand and it will do this only with regard to the medical care or future medical care, whatever it is, of a patient. Don.

MR. TAYLOR: I still think that when the pharmacist logs on to a terminal, he is identified. And, therefore, in David's system you always know who's making that request.

JUDGE FADER: Well, see, I don't know that one way or another as to who the pharmacist --

DR. FARAH: But that won't change the law.

JUDGE FADER: -- is on the terminal.

DR. FARAH: The law -- you should have an access number.

MR. TAYLOR: But if your law says you have to have a separate log-in number --

MR. GANDHI: You're actually saying the entire electronic medical record, under this system, so do you log in a second time to access the prescription data?

JUDGE FADER: Well, for Surescripts, can that

tell what the pharmacist's name is that filled the prescription?

MR. TAYLOR: Yes.

MS. BETHMAN: Yes.

JUDGE FADER: Okay. Well, then, if that is so then they will just let that pharmacist use that number.

DR. MARTIN-DAVIS: Don, wouldn't you potentially have a problem if you've got a CVS pharmacy that's busy, and you're the head pharmacist and you log in and then you're doing X, and you say, hey, pharmacy tech, get Ms. Johnson's script?

JUDGE FADER: That's the pharmacist's fault. It's the same thing as these stupid pharmacists that sign these -- only certain pharmacists can sign order forms for CDS. Okay.

I've had some people, some kids who have worked in stores, that have said they see these things in the safe signed in blank. All right. Those pharmacists are nuts. They are absolutely crazy.

I can only tell you I tell my pharmacy students, don't ever sign anything in blank. You know, I can't help it. Remember what it says in the 26th chapter of St. Matthew: the idiots shall always be with you. That's in the Koran and it's in the Torah, too. But you can't protect against all these people that are just so stupid to do stuff like that.

MR. SHARP: Point of reference. You can choose to add complexity to a sign-in process for authenticating users, if that's what you wish.

However, you can get the same protections when you credential in the users, by signing on a roll-based purpose so that if it's a physician who has access to it, as part of the registration they're given permission to do certain functions and view certain records as part of their log-on and password.

It actually has three. You can layer the log-on password and then the unique identifier just as a protocol to get access to the system anyway. And then once they are in, it audits and tracks back to that user all the time. Or if you desire, you

still --

JUDGE FADER: This is all mechanisms. The fact is that any pharmacist or any physician has to be identified before they can have access to the system.

MR. SHARP: Well, they are.

JUDGE FADER: Yes, but whether or not they can use their own CDS number -- who in the devil cares? That's up to the committee to work that out.

MR. FRIEDMAN: You talked earlier about the consumer having access to the system. So I assume a consumer would also, if they wanted to access the system --

MS. BETHMAN: Not direct access.

JUDGE FADER: No, the consumer access -- the patient access to the system requires, in every state, a written request that's available online to send it, and then send them the data by mail.

MR. FRIEDMAN: So a pharmacist could look up information on themself if he had access to the system, right?

JUDGE FADER: Yeah. Who cares about that?

MR. FRIEDMAN: Okay. Only the pharmacist that's abusing.

MS. BETHMAN: But it's there. He would be able to get it anyway.

DR. WOLF: I have a question with regard to the relationship of a patient and what constitutes and what doesn't. I am very clear on when somebody is my patient. I'm also very clear on if it's an IME that's not my patient, or if it's a forensic evaluation that's not my patient. But what happens, and there are a lot of company physicians --

JUDGE FADER: Everybody understand what an IME is? Independent medical examination.

Okay, in other words, some physicians will do an IME for a party for claims against insurance or litigation that want another physician to do an IME, an independent medical exam. Okay.

Well, one of the things that physician can say is that I need access to your drugs in order for me to complete my IME. And, believe me, I would sign that any day.

DR. WOLF: You would? Okay. So you would consider that. So then a question that comes is, again, in a clinical trial situation where you're doing a lot of diagnostic. They may be doing very limited therapeutic, which would be the trial drug. But the information is extremely valuable, especially if they are checking for controlled substances.

So does that fall under a bona fide physician/patient relationship, or does it fall under a special category?

JUDGE FADER: If the patient submits themself to clinical trials, yes.

MR. SHARP: They do. They signed consent forms, yeah. They do all that already.

DR. FARAH: If they consent, then it's your patient at that time. And if there's an adverse effect, it's going to follow the policy and procedures of what gets signed.

JUDGE FADER: Now, let me go over this recommendation again with regard to dispensers and practitioners.

Any dispenser or practitioner may have access to the system provided, one, that there is a legitimate medical relationship, whichever language you're going to put in. The thing last year read, in connection with the medical care of a patient, in connection with the dispensing of a monitored prescription drug. I would suggest to you that's what most states say.

And secondly, that they have identification to get them online, immediate access. Does anyone have any questions with any of that as far as dispensers and practitioners?

(No response.)

JUDGE FADER: Okay. Number 2.

DR. FARAH: The wording in Vermont I think is one of the most clear wording. If you want to look at that, please.

JUDGE FADER: Okay. Number two, the police. Can I give you a brief little legal history lesson?

When the Constitution says no person can be deprived of life, liberty, or property without due

process of law, and that a warrant to search and seize must be upon probable cause that a crime has been committed or is about to be committed, that's not what we are talking about here.

Number two, that the Attorney General's Office and the State Police and the State's Attorneys and the Justice Department have the right to issue a subpoena, pursuant to an investigation, where they are bound by their oath only to do that if there is an investigation. They are not required to show probable cause.

When that comes before me, the Attorney General's -- say the Consumer Protection Division, issues a subpoena. My only responsibility, if someone objects, because, you see, the Attorney General cannot enforce his subpoenas. He has no authority to do that. If somebody disobeys his subpoena, he must come to me.

All right. When I look at that, all I see is, is this certified to be part of an investigation, and is it within the statutory powers. I don't do

anything as far as probable cause, because that's not a part of it.

If the legislature has granted that right to subpoena, pursuant to an investigation, the Attorney General, the State's Attorney's do not need probable cause. That's the second part.

Okay. So when we're talking about the police, we are talking about the issuance of a subpoena. And we are not talking about any requirement that they have probable cause, because there are not seizing any property.

We are talking just about pursuant to their investigatory authority, and they have said that they are in a position to say that they would proceed to this database to the issuance of a subpoena. Which means that's it. No necessity for probable cause.

In my opinion, that's the way it should stay for two reasons. First of all, I think the Constitution pretty much says they have that authority anyhow, and that we can't impose probable cause on them.

Secondly, because of the fact that nobody's had any great complaints. So, with regard to the police, when you say that they would access it through a subpoena, that's what they mean. Any questions? Any comments about any of that? Any objection?

DR. WOLF: Is in that list you said that basically people had the right to not comply, but if the person whose data is being gathered is not informed, they don't have the ability to deny access to it?

JUDGE FADER: That's correct.

DR. WOLF: Okay. So there is no five-day requirement or anything like that?

JUDGE FADER: No.

DR. WOLF: Okay.

JUDGE FADER: There are statutes that have a five-day requirement, such as financial information and things like that. But there's also a provision in there that I can waive it. And when a police officer swears under oath to me that it's pursuant to an

investigation that that police officer is conducting, which he says is legitimate, then I waive it.

You should see the financial data of Baltimore County who they've been investigating that -- what can I tell you. That's all sealed and sent downstairs. Everybody understand that? Anybody have any questions with any of that?

(No response.)

JUDGE FADER: Remember now, it's not probable cause. It's not for the issuance of a warrant that a crime has been committed. The police have the authority to issue subpoenas when they have a suspicion of crime having been committed.

MS. DEVARIS: And I think that's the difference between many of the disciplinary boards --

JUDGE FADER: Well, we're talking about the disciplinary boards next.

MS. DEVARIS: Okay.

MR. FRIEDMAN: This piece for Recommendation No. 6. Does this one, or is it another one that addresses how one health care provider can communicate

with another one?

JUDGE FADER: That's all within the Confidentiality of Medical Records Act.

MR. FRIEDMAN: Okay.

JUDGE FADER: That doesn't have anything to do with this. Okay. In other words, if Bob Lyles gets online and he takes a look at the database, and he sees that this patient has gone to six different pharmacies and he records that in his record, he has a right to communicate that to Marcia Wolf, who calls him up and says, hey, Bob, what about this patient? He has a right to do that.

MR. FRIEDMAN: So if a pharmacist sees that there's potential abuse, they can contact another pharmacy or a physician that's also serving that patient, to let them know?

I'm asking that because for some reason Virginia, unless they've changed it, specifically says in their rules that you can only say, I advise you to check the database. You cannot tell them what is there.

JUDGE FADER: For a pharmacist or a physician to pick up the telephone and go around calling other physicians, they're going to get themselves in trouble.

It's when a physician calls and says, Hi, Ramsay, this is Marcia. What information do you have on that patient? He can then tell her.

He is not supposed to go out and say, we're at this meeting of the addiction society. I want to talk to you. John F. Fader II, date of birth 2-12-41, watch out for this guy. He can't do that.

Okay. What he can do is that if he calls to ask for information, he can give that information to somebody else. That's inherent and implicit in the Medical Records Act. Okay. But he does not go out calling other people.

MS. JOHNSON-ROCHEE: I was just going to add what that pharmacists should be doing, though, if he sees information in the prescription monitoring record, and there's indicators by what he sees standing behind his counter, his customers, he has a corresponding responsibility to exercise. A lot of pharmacists do

that sometimes.

JUDGE FADER: But he has the responsibility there not to fill that and he can pick up and write on this, too many problems in database.

DR. WOLF: He's expected to call the physician.

JUDGE FADER: He can call the physician, but he can't announce at the next meeting of the Maryland Pharmacist Society to watch out for this person.

DR. FARAH: I've received calls from pharmacists saying, I've got your prescription on this patient. Do you realize five days ago this person filled this prescription?

JUDGE FADER: He can do that.

MR. CLARK: Can he not contact any law enforcement agency?

JUDGE FADER: Yes, he can do that. That's correct. But he can't call around to different pharmacies. And there have been things of this sort.

Somebody presents a prescription to the CVS store, they refuse to sell it. The CVS store -- and

I know some pharmacists that have done this -- calls to Walgreens across the street, calls to so and so, calls to this one and says, watch out for this guy. You are not supposed to do that.

DR. MARTIN-DAVIS: I'm just curious. This is off-topic. If pharmacists see a prescription that they think is fraudulent, it's 10:00, they can't get the doctor. Are they supposed to keep it?

JUDGE FADER: No, they can't keep that, that somebody else's property. They have to give it back.

DR. WOLF: They can say, I don't have it. I should have it by tomorrow morning. Why don't you come back then?

JUDGE FADER: No, they can't say that.

DR. WOLF: No? Okay.

JUDGE FADER: We tell our pharmacists never to lie. All you can say is, I don't feel comfortable with filling this. They say, why? Because I don't feel comfortable with filling this. But never tell a lie. You start doing that, then you start to lie to women, parents -- I'm making a joke here.

MR. FRIEDMAN: But if you call the physician and the physician says, I did not issue that prescription, you can --

JUDGE FADER: You can write across the front of it, physician says did not issue this prescription. Put your notes on it. I tell the pharmacists, take a photocopy of it and keep it.

DR. MARTIN-DAVIS: So they can keep it?

JUDGE FADER: Keep the copy.

MR. FRIEDMAN: But you can deface the original so it can't be filled.

JUDGE FADER: Okay. All right. Any question then with regard to law enforcement?

(No response.)

JUDGE FADER: Now, the disciplinary boards. The disciplinary boards and the Consumer Protection Division of the State of Maryland, and other boards have been given the authority to issue subpoena.

Their subpoena authority is the same as the police authority. The subpoena, in each case, must be issued over the signature of the executive

director for the -- what do you call the one in the Attorney General's Office?

MS. KUHN: In the Consumer Protection Division; it's the Chief.

JUDGE FADER: -- the Chief must be over the signature of that person who certifies that it is for a legitimate investigatory purpose. Okay. They also cannot enforce their own subpoenas. They have to come to me.

But, once again, when that happens, I have no authority whatsoever to question why. I only have the authority to require them to say it's for a legitimate investigatory purpose.

Now, Linda, the boards don't mind, do they, giving up power and having everything only on probable cause?

MS. BETHMAN: I think they do mind.

JUDGE FADER: Well, I asked you to inquire upon that. So what did you find out when you inquired?

MS. BETHMAN: I spoke with counsel for --

well, I'm counsel, obviously, for those who didn't know, to the pharmacy board.

I spoke with counsel to the nursing board, spoke with counsel to the physicians board, and it's really not a legal issue. If the General Assembly makes it so, then it's so.

JUDGE FADER: We don't know the answer to that question, but go ahead.

MS. BETHMAN: The feeling from the staff, the executive directors who, as you say, sign those subpoenas, was that they would like to retain their ability, their independent subpoena authority. They do a lot of investigations. They don't want to have to send an attorney to court for everything.

JUDGE FADER: Once again, so that you understand, because I want you to understand that there is sometimes great friction between the healthcare disciplinary boards and some of the physicians in the State of Maryland, that the statutory authority says that a subpoena may be issued by a board, over the signature of the executive director,

the president, has to be something. Okay.

Somebody disobeys a subpoena that comes to me in court, I look and I take an affidavit of Don Taylor that says, I certify to you that this is for a legitimate investigatory purpose. I have no authority to question him as to what that is. I have to take his certification as to what it is.

If it's within the scope -- in other words, if he's investigating to find out if someone is running a child pornography thing out of the basement, that's none of his business as far as the disciplinary authority. Whether for drugs or incompetence or something like that, it would be, then I would have to order the subpoena.

MR. TAYLOR: The subpoena has to be within the scope.

JUDGE FADER: The scope of what the pharmacy -- but I don't have any reason to suppose that I have the right to ask him what's the investigation about, whether he has probable cause, or anything of that sort. The disciplinary boards want that to stay

the same. Any objection to that?

DR. WOLF: So that gets back to how they will access the system. They'll do it with just their direct link then.

JUDGE FADER: Well, no. They have to issue a subpoena.

MR. TAYLOR: That would be for a specific report on a specific patient. It wouldn't be just for general information.

MS. BETHMAN: Well, you wouldn't be able to issue a subpoena on general information anyway. It would have to be specific.

MS. DEVARIS: Can I weigh in on this for the Board of Nursing. Our subpoenas are signed by either the executive director, the deputy director, or the president of the board. Our subpoena authority is based on, as you say, a legitimate investigatory purpose. That purpose is most likely going to be related, in fact will be related, to a specific violation of our practice --

JUDGE FADER: I understand that but I don't

have any right to inquire about that.

MS. DEVARIS: Right. And we also are not doing criminal law, which is a distinction. We are in the administrative law field. So it gives us a lower standard for proving what we need.

JUDGE FADER: We think.

MS. DEVARIS: We think, too.

JUDGE FADER: All right. But let me tell you about this. I looked at five or six different statutes and I could find no annotations under there as to what the authority of a circuit court judge was. None.

I have never had a case of that sort. So I did the best thing I possibly could. I dialed the telephone and I called Charlie Moyle, okay, who is from the Court of Special Appeals. One of the smartest men in criminal law you are ever going to see. I said, Charlie, this is what I found, but I can't find a case. Give me a case.

He said, John, I don't think there is a case. He says, I think everybody has assumed that what you're saying is correct and nobody has ever

challenged it. I have never come across anything of that sort.

I said, Well, I now have more confidence in my research ability, Charlie. That is what he said. There is no case that he knows of but he feels the law is exactly the statement of mine, and those lawyers in the room know there's nobody that knows more about criminal law than Charlie Moyle.

So that's the reason I say that I've always assumed that that's so. So, therefore, do the physicians, the practitioners, and the dispensers have the same authority that we've talked about? Do the disciplinary boards have the same authority that we've talked about? Do the police have the same authorities to the subpoena power that we've talked about? Does everybody approve all that?

DR. MARTIN-DAVIS: You said the executives of the boards would have direct links to the system?

JUDGE FADER: No. They can only issue a subpoena. Other states have given someone in their medical board and their pharmacy board or something of

that sort direct access to the system in investigation. Maryland proposes not to do that, to require them to continue to issue a subpoena.

DR. WOLF: They can have access but it's indirect. So we've got direct access for clinicians and providers, and indirect access for law enforcement.

JUDGE FADER: Through a subpoena. Any further discussion on this point? All in favor, say Aye.

DR. WOLF: Aye.

JUDGE FADER: Any nos?

(No response.)

JUDGE FADER: Okay. No. 8, Confidentiality and Security.

DR. WOLF: Who will the individual patient go to, to access their data? Who will actually be the one that pulls it up and mails it to them?

JUDGE FADER: Someone that is designated by regulation in the Secretary of Drug Control's Office. It's all done the same way.

There's a number of states that allow

direct patient access. There's a number of states that don't. All of the states that do, have a form online. They have a person designated by regulation to take care of that. And that person receives the request and the $5.00, or whatever it is, and sends it out the next day.

DR. WOLF: Do you think there's actually going to be allowed a fee to go along with that?

JUDGE FADER: It should be.

DR. WOLF: Even the indigent, or people that --

JUDGE FADER: Look, let me tell you how we take care of indigents now in the law system. You have to pay. But I'm poor, I can't pay. Look at me, you telling me the truth? Yes. Then we give it to them free. That's how we work it in the judicial system.

DR. WOLF: Okay.

JUDGE FADER: All right. If it's anything over $50.00. we make them sign an affidavit. But if somebody appears at the window of the clerk's office, all right -- unless they're dressed snappy like Don or

David -- and they say, I can't afford this, the clerk just looks at them and says, you telling me the truth? Yes. Okay. And then they just give them their copies for free.

It probably doesn't amount to any more than a couple hundred bucks a year. Now, don't you two go to the clerk's office. But, I mean, the practicalities of all this is this can set you nuts about all of this. So that's how we work it in the court system.

DR. WOLF: I just didn't want it to be a roadblock for the legislature.

JUDGE FADER: No, it's not. It's the same thing. The Public Information System works the same way, doesn't it, Linda?

MS. BETHMAN: Yes.

JUDGE FADER: I mean, all you have to do is say, I can't afford this. I'm on welfare. I lost my job. Whatever it is, they just give it to them for free. It's just easier and cheaper. Anything else?

(No response.)

JUDGE FADER: All right. Here's the thing with confidential. Number one, the integrity of the system is all-important. Number two, criminal penalties. Number three, civil penalties. Number four, disciplinary penalties. Look at the first paragraph, please, on page one.

(1.) The data system utilized must be of the highest quality.

David, you agree on that? You're not going to select a data system that's not.

(2.) Unauthorized access should be punishable by disciplinary actions against healthcare professionals.

Ramsay has already said there's a number of physicians that have been disciplined.

(3.) Unauthorized access should be punishable by criminal penalties (misdemeanor) -- remember, we voted not to make it a felony -- and a system of civil penalties that can be obtained by a patient whose confidentiality has been compromised.

DR. MARTIN-DAVIS: Does this include staff,

as well as staff in the AG's office? Something like people who legitimately are trying to do the right thing getting information --

JUDGE FADER: Nobody in the AG's office has any authority to do that except by subpoena.

DR. MARTIN-DAVIS: Sorry, that was a bad example.

JUDGE FADER: If Marcia gives it to her secretary, or her nurse, and says, you do this, she deserves every bad thing that's going to happen to her. Okay. The thing is that physicians are only to access this system. Nicole, any other questions?

DR. MARTIN-DAVIS: No.

JUDGE FADER: All right. Marcia.

DR. WOLF: With the civil penalties and the criminal penalties, my concern is that if the data is out there, and whether a patient got it mailed themselves or it winds up in some place, it seems to me as if the only assumption that will be made is that it came from the clinician. Are they going to have to prove the chain --

JUDGE FADER: It's all subject to proof.

DR. WOLF: Okay.

JUDGE FADER: The Medical Records Act of the State of Maryland now has all sort of civil penalties for the dissemination of that information.

I told you that the only case I have ever seen is -- I have gone through motions in the Circuit Court for Baltimore County now where someone is supposed to have accessed a psychiatric record on a nurse at Sinai Hospital, and told people about it.

DR. WOLF: The other issue along with that is, though, if it actually gets printed and placed in the chart, and then the chart is subpoenaed, record requested, whatever, and photocopied and it goes from there. So the way I am reading this is I would never -- at this point I wouldn't copy it and stick it in the chart, because I don't want to take the chance that it's going to get photocopied with a chart request, or with a record request, and get sent to the wrong place.

I would like to be able to have it in my chart as documentation that I did it, but under these

circumstances, I'm not going to do that.

JUDGE FADER: That's correct.

DR. FARAH: What I recommend is --

JUDGE FADER: Surescripts, you know, is read-only.

DR. FARAH: Yeah, and many places have read-only, by the way. What I would recommend in a situation like this is to have a stamp, red, in confidential. Stamp it on a sheet of paper. And be the modus operandi in your office is that if there is a sheet of paper with confidential red stamp on it, just like a mental health record, it doesn't go --

JUDGE FADER: See, I'm not exactly sure that that's going to make any difference because we allow access to everything that is not a psychiatric record. Okay.

Now, I can tell you now, few people realize it but Maryland's Confidentiality of Medical Records Act is much stricter than HIPAA,s. I cannot remember when I've ever signed and allowed a subpoena or have denied a protective order against a medical record.

It is almost absolute. You cannot get at it.

Unlike the federal law, upon court order and things like that, there is no provision in the state law for what court order means, or anything of that sort.

We just haven't had any problems with it because it's just been so strict. So what are they going to get? They are only going to get it through medical records if you're sued, or some patient is coming into court to sue based upon your treatment of that patient because the patient is suffering pain. That's it.

Once those records come in to me, they are public records but I put them in an envelope that says For Court Use Only. If anybody wants to come in and take a look at them, they can take a look at them, but I don't want them in the file.

I can only let them take a look at them if they are evidence in the case. Until they are evidence in the case, I don't let anybody look at them. Any questions, any comments about any of this?

Yes.

MS. DEVARIS: In response to Nicole's concern, every board has a code of ethics and they have a code of conduct for their investigators. I don't know if all the boards do that. We do, and if they were to subpoena a record that was not subsequent to a legitimate investigation, they could be punished and subject to sanction.

JUDGE FADER: We understand that.

MS. DEVARIS: So there are other layers of safeguards to protect the confidentiality of these records.

JUDGE FADER: I understand that, too. Historically, investigative records are not open to the public anyhow.

First of all, you have an attorney sitting there and a lot of that is an attorney's work product, which is not discoverable -- say, here's what you should do. You should go out and get this record, you should do that, you should go out and get that record. That is their work product, okay, and

you can't get an attorney's work product.

DR. WOLF: Can you get mine?

JUDGE FADER: In what sense?

DR. WOLF: My handwritten notes.

JUDGE FADER: Well, if they are part and parcel of the diagnosis that you made, yes. That's not your work product. That is part and parcel of the treatment record. But you can only get that if the patient has put their treatment on the line in the case.

Someone can't just subpoena the records, your records, and get the records just because they want to. That patient has to somehow have put that patient's medical condition in the file and on record as part and parcel of the litigation.

DR. WOLF: Well, they do it all the time in a worker's comp case. They give the insurance company the right to the record.

JUDGE FADER: That's correct. But I have it all the time in domestic cases, that they say that so and so is going to see Dr. Wolf. I want to get to see

what Dr. Wolf treated her for. They can't get at those records just because she's involved in a custody case.

Now, if somebody goes to workers' comp and is making a claim where somebody is suing and going to you for pain medication and you're going to come in to testify in court as to the injury, then they are putting their medical condition on record so they can get into your records. But that's only because the patient has put their records into controversy. Anything else with regard to No. 8?

(No response.)

JUDGE FADER: With regard to No. 9, Housing of Database. That's with Georgette and LaRai. Just like the atomic bomb, one of them will have one key, one of them will have the other key. Any questions about that?

MS. DEVARIS: Would this change if we use the HIE?

JUDGE FADER: Yes. But you would still have to have somebody that would monitor access through Georgette's office.

In other words, she would be somebody that could turn that key. David likes to speak in terms of what switch you are going to turn. She would be the switch in the office that would turn. Any questions? Any comments?

DR. MARTIN-DAVIS: David, do we know where, if we went with the HIE program, where the system would be?

DR. FARAH: Nothing.

JUDGE FADER: Last is Data Mining. Bruce.

MR. KOZLOWSKI: Good timing. First, thank you for the accommodation. I appreciate it. Okay.

JUDGE FADER: No. 16. Miss Kitty's saloon doesn't close until 2:00 in the morning so we all have time to pick our guns up.

MR. KOZLOWSKI: You want me to start?

JUDGE FADER: Sure do.

MR. KOZLOWSKI: Okay. Thank you very much. The data mining thing. If we just step back, leave our emotions back with Miss Kitty and our guns, and let's think about the practicality of what we are doing here.

We are building access to a tremendous amount of data that has the capacity not only to deal with the medical management side and the diversion side, but to strongly and heavily support public health and also public policy.

There's a mass of information through data mining which, when heard back, I believe in 2006 or 2007, according to Dr. Lyles, for purposes of public health, there was not a concern about doing it to support that particular capacity.

But, think about the example I used, if you all read this, was H1N1 because it just happens to be dominant in the media today.

The amount of information that was needed to address that, we would have had a database, a phenomenal database, to help support that capacity. I would expect, prospectively, from what my colleagues in the Navy Seal group, say, we will have needs of a different kind, potentially in the future, that will be even more egregious than H1N1, in which having access to information for emergency response

will be very, very important.

So that's the easy one. I will be surprised here, but then I've been surprised in life about folks being concerned from a public health standpoint. Go ahead.

DR. WOLF: I actually have a question about that. Does that need to be part and parcel of this legislation, since the data that we're going to be pulling out is going to be HIE data, and you'll already have access to that HIE data yourself to do with public health wise, whatever you wish? So it's not like you need a separate PDM body of data --

MR. KOZLOWSKI: You're going to turn with the other side.

DR. WOLF: Okay.

MR. KOZLOWSKI: Okay. There's two sides to every coin, and good politicians start on the easy side. So on the front of this page is the easy one, and that's talking about public health.

Let's flip to the other side. The other side created a tremendous amount of rhetoric,

dialogue and emotion, I understand, the last time around. Let me just suggest, and let's go through it, read it and understand it.

Access to information section of the report that allows states' agencies and academic institutions to request data extracts from the governing body for the purpose of data analysis to support public health -- you didn't have a concern about that -- and public reporting is defined in the statute or regulations, et cetera.

They would have to submit an abstract, which we required for our information data source already, and outlining the basis and the purpose and the data would be extracted and provided to the requestor, be de-identified unless the data supporting was a public health organization.

I would expect that from -- if you have any history with what the commission produces, the commission mines all kinds of information already. And by about the year of 2014 or 2015, we will have in place pharmacy, physician, hospital, and we will

have it from the enrollment files of the health plans.

So that legislation -- the regulations for that just passed in the last couple of weeks and the information is being disseminated. So there is going to be a huge data body out there, and it was just to cover the aspect that when you do mining, it always tends to cause people to get concerned that you're going to mine for purpose of sending it to law enforcement.

I just wanted to emphasize -- and we may consider whether it needs to or not be needed to in a report -- to say that data mining, for purposes of public health analysis, wherein there would be a severe penalty if anybody did anything but use the data for reporting purposes, none of it would ever be referred that was found in this scenario for law enforcement.

Okay. But it came up last time, and it was a really, really big contentious issue. You may have been involved in that discussion, I don't recall.

Dr. Lyles, I know, felt very strongly about the fact that it would be a real loss not to be able to have designated people going in there and --

DR. FARAH: No question. And that's part of the reason why I felt a technical committee could play a role.

There are certain merits in having canned reports. These reports are studied, there's a purpose for them, there's an objective, there is a value. Is there a good reason why we should have to continue this program? What kind of general information are we getting that's going to help us have policy and procedure and patterns in areas, you know, et cetera, et cetera.

There's a difference between data mining to go on a witch hunt to try to get somebody. This is two different things completely. When I mean data mining, I mean data mining like they would do at an insurance company. Look at patterns, look at opportunities in management and savings and policy, et cetera.

These are aggregate data. These are filtered data. They have to be validated. I mean, the scrutiny of not double -- it's a very highly technical area to get information so that we can make appropriate decisions, which is completely different than data mining looking after one person to do one thing --

MR. KOZLOWSKI: Sure. Then the other part of this is when you are doing data mining and you are sorting through and you see aberrances. We talked about that earlier today of sending it to the attending physician and the dispenser so they become aware of what's there, that something is occurring. It doesn't say it's good, it doesn't say it's bad.

But those systems have been around for years, and it would just be a shame to isolate this thing and make it so insular that we have a capacity that we're not using to the maximum.

MR. FRIEDMAN: In some of the PDM legislation that passed in Maryland a couple of years ago, they addressed data sharing. They specifically said it was

okay if it's to look at utilization patterns, to administer the formularity, benefiting administrations, those sort of things.

Obviously, what we are concerned about in those situations is buying and selling for marketing purposes directly to the consumer.

DR. WOLF: The only concern I would have with something like that is if that, by de facto then -- what you find, by de facto, becomes what is classified as the standard of care.

You have a bunch of cutting edge institutions and different factions that are doing cutting edge things. So they may, by definition, fall as an outlier. And I'm not necessarily talking about PDM data. I'm talking about public health, whatever it happens to be.

If that was then translated to be, this is the standard of care, that's a problem.

DR. FARAH: I'm sorry to say this, but I deal with standard of care for the last seven years. The standard of care is defined in Maryland through a peer

review system, in the disciplinary arena. And in the civil arena, it's the expert witnesses who are going to be testifying on case-by-case basis, et cetera. So there is no statute that states --

JUDGE FADER: -- depending upon whether they passed the judges' scrutiny as to whether or not there is a basis for the expert opinion coming forth. Because we have a bunch of whores, or have gun will travel, that would testify that it's snowing out in July if you pay them. So judges have a great deal of discretion over what to admit, and what not to admit, depending upon the science.

DR. WOLF: But this kind of data has never been available before.

DR. FARAH: But you don't even know who these people are. If there's a complaint against a practice or a physician, or an investigation where they took five charts, they take these five chart, give them to two independent doctors in the field, peers, they look at them. They give a report on each one of these elements and determine if they agree whether the

standard of care is met. You have a chance to look at it, review it, discuss it --

DR. WOLF: But that's the definition of the standard of care as it exists now without access to the kind of data of what hundreds of thousands physicians in the state are doing.

Is there anything that is going to prevent what we find physicians are actually doing from becoming the standards of care?

DR. FARAH: Excuse me. If you look at my records I only have Methadone and Buprenorphine prescribed. I don't have much more than that. So what's the standard of care. If you're going to compare it to me, everybody should be on Methadone and Buprenorphine.

JUDGE FADER: Marcia, the question you are asking is one that has plagued the medical profession and the labor profession for years.

Will the legislature ever codify that this is the standard of care, or that's the standard of care? Not in the foreseeable future. Because the

reason is, it changes tomorrow. Okay. The second changes in five minutes. The standard changes in five minutes. Okay.

DR. COHEN: My experience is certain judges -- most are not but some are -- but that's the process of appeal. There is a legal way to go about doing this. I can't worry about the perception.

JUDGE FADER: The situation is that every medical malpractice case, everything of this sort, you have me instructing the jury that you listen to the expert as to what is the standard of care.

Do the juries make the right decisions in all the cases? Absolutely not. Do they, in my opinion, make the right decision in the overwhelming majority of cases? Yes. But that's just part of the system.

DR. WOLF: Having sat in the Med Mutual presidents' meeting last night and having the four decisions that have come out of the Appellate and the other courts, there's been a lot of talk lately. One was an informed consent case on an act that never took

place. One was -- they are various and sundry, but there are these four cases --

JUDGE FADER: I know. Some of my best friends have been writing some of those decisions. Okay. We don't all agree with them, and a lot of those decisions are four-three, things of that sort, with a lot of dissents. Unfortunately, God's favorite color is gray and a lot of these things are not to a bright line ruled. Anything else?

MR. GANDHI: One point. The last sentence here in the recommendation, we are leaving the door open for identified data to be released in the case of public health emergencies.

MR. KOZLOWSKI: For public health you don't have a choice. When it gets down to a national crisis, the Secretary has access and authority for anything.

MS. BETHMAN: The Governor can lift the laws.

JUDGE FADER: All right. So what are we going to do about this data mining thing? Bruce, what do you suggest we do about it with regard to this report?

MR. KOZLOWSKI: Well, if anything, it should be at least one of the functionalities of whoever the administering agency is. Data mining, for the purpose of supporting public health and for the purpose of public reporting and the purpose of informing attending physicians and prescribers of aberrant practices observed ought to be in there as part of their charge.

DR. COHEN: Okay. Does it go through an IRB process?

MR. KOZLOWSKI: It can be. It hasn't in the past because there's nothing there but a pool of data. That's all you send them is a report saying, here's something you may want to look at. Okay. And it's based off of software. It's not somebody sitting and being subjective.

There's software out there that says, here's something that may be worthwhile taking a look at and that's why you're sending a look at. It may be worthwhile taking a look at.

JUDGE FADER: Okay. The big question is, do you want it to be one of the responsibilities to send

it out, or is it just a responsibility to have the information available in case somebody asks for it?

DR. FARAH: I think that's why you have the technical committee, to look a that and see what are the merits of this. I mean, that's part of why you want to have people who know what's going on to help guide this.

I don't think you can qualify it in legislation but you surely can't put a group of expert people to sort out what does this mean.

JUDGE FADER: How about me putting a little commentary, to the role of the advisory committee, to the effect that they really need to consider this, and to consider to fund what application, and things of that it should come out. All right?

DR. FARAH: I think it appropriate to have data mining for all the reasons he mentioned.

JUDGE FADER: All right. Last, I refer you to the letter of May 26, 2006 from Bob Ehrlich.

Question number 1, the reason he vetoed this was because of the aspects of the funding. On

the first page of his letter, I think we adequately addressed that. I don't think there is anything more than we can say upon that.

He called, you know, how much is it going to cost and everything, that he really didn't have a good grasp on that. I think that we've pretty much taken care to whatever extent.

Does anybody have anything to say about that? Does anybody disagree? Agree? Anything else?

(No response.)

JUDGE FADER: I hear nothing.

Number 2. He indicated that he felt that the bill was wanting because there was too much potential for encroachment on adequate pain management, individuals suffering chronic pain and had a chilling effect.

It seems to me that we have pretty much addressed -- this is the last two pages on Recommendation No. 1. The second paragraph, the one at the bottom of the first page. He vetoed it because he said that he felt it was an encroachment

on pain management. People were suffering.

It seems to me that we have pretty much adequately address that and the legislature has addressed that by making non-interference with pain physicians as one of their greatest priorities. Anybody have any comment? Anything on that?

(No response.)

JUDGE FADER: Top of page two. The patient confidentiality was not properly addressed. He felt in that bill stigmas associated with certain diseases.

I suggest to you that we have more than adequately addressed that and that we need do nothing further. Anybody have any questions about that?

(No response.)

JUDGE FADER: Second, he didn't trust the DEA. Certainly, knowing Mary, we can see how that could have occurred. No, love you, Mary.

Frankly, the DEA could search the database for the purpose of finding offenders to prosecute. I didn't see that in the initial bill.

I don't know how Governor Ehrlich saw that

in the initial bill but the fact is that's all through subpoena power now so it just seems to me that is no longer a worry. Anybody have any questions about that?

(No response.)

MR. CLARK: I think Jervis Finney didn't like us.

JUDGE FADER: Well, when Bobby was Governor -- he was my legislator and used to walk up and down the streets. Jervis use to -- when I saw him down in Annapolis he use to constantly remind me that I didn't rule for him in every case that was before me. I said, well, that's because I didn't think you were right.

Fourth, emphasizes law enforcement over treatment. We sure have spoken about that. Their objectives, I think we've placed them as well as we can. Anybody have any questions about that?

(No response.)

Next, creates an advisory board after legislation. Truly advise DHMH on how to implement

the successful prescription drug. I don't agree with Jervis on that. Everybody understand we're talking about Jervis Finney who was the Chief of Legal?

Okay. It just seems to me that we have put forth this pattern that certain things should be in the statute itself, but certain things need, with regard to implementation and everything, to be developed, to be put forth through regulations, to be put through policy, and that we done what I think is a pretty doggone good job of indicating this is created in statute, this needs regulations, this needs advice, et cetera.

I didn't agree with that when I read that. I don't agree with it now. Anybody have any questions with that?

(No response.)

Michael is going to call me Tuesday. We're going to meet by the end of the week. We are going to have a draft out, which will not be the final draft that will be sent to you because we have to get things under way for all of the state agencies to

check. We'll then work on these changes and get them out for you, individually, one by one, and ask for any comments.

As you have seen with regard to these materials, everybody who want to put an objection in for one reason or another has the right to entitlement to a footnote and I hope you all agree that we can continue with all of that.

I had no idea when I became involved with this that there was so much information out there. There is too much information out there. You can set yourself nuts with reading and comprehending all of this stuff.

It sure is a pleasure to know you all, and I hope we see each other again soon. But if anybody doesn't have --

MR. CLARK: When is the Christmas party?

JUDGE FADER: We'll get together every year on December 4th. Marcia will buy lunch.

Seriously, I haven't been with too many groups that have had so much good things to say and

so much insight and so much concern for their respective positions such as this. And on behalf of the Secretary, we thank you all.

DR. WOLF: Thank you, Judge.

DR. FARAH: For the single dissenter about this whole thing, I guess out of the whole group that you had here when we first got started, I just want to tell you how much I appreciate the privilege and the opportunity to work with you on this, and what a phenomenal and very organized way you led us through to get where we are today.

JUDGE FADER: Thank you all very much. We'll see you. Take care.

(Whereupon, the meeting was concluded at 3:07 p.m.)

I, Kathleen Vetters, a Notary Public of the State of Maryland, County of Baltimore, do hereby certify the within named witness personally appeared before me at the time and place herein set out, and after having been duly sworn by me, according to law, was examined by counsel.

I further certify that the examination was recorded verbatim by me and this transcript is a true record of the proceedings.

I further certify that I am not of counsel to any of the parties, nor in any way interested in the outcome of this action.

As witness my hand and notarial seal this 18th day of December, 2009

_____

Kathleen Vetters, Court Reporter

NOTARY PUBLIC

My Commission Expires: November 19, 2011